THE MATTHEW PROJECT: BRIDGING THE SELF AND THE SACRED

A Study from Hospital to Home of Pastoral Encounters

With Spiritually Disengaged Patients

By

Mary T. O'Neill

A DEMONSTRATION PROJECT

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ABSTRACT

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MARY T. O'NEILL

In maladie life comes to an abrupt pause. In that pause is an unanticipated time for reflection and evaluating life's direction. When people are challenged by life's circumstances to look inside, they can find resource for strength and courage in their spiritual selves. However, when this spiritual self has not been attended to, or even ignored, the pain of that spiritual void can evoke intense spiritual pain and even despair. Chaplains are trained to be with such patients, to journey with them in their questions of meaning and direction. In today's medical world, the short hospital stay presents a challenge for any significant follow up beyond the first visit. Thus was born the Matthew Project. Its focus is on providing follow up telephone conversations to willing patients post discharge, in order to assist their further reconnection with their spiritual selves. Herein are the findings and the implications for worship communities they inspired.

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INTRODUCTION TO THE MATTHEW PROJECT

In my 20 years of supervising students of pastoral care in the Clinical Pastoral Education program, I have noticed, as we spoke of their patient visits, how many times they would report visiting a patient who was not at all connected to his or her inner spirit and who through this hospitalization had begun to ask questions about what life was about. Other questions that surfaced at such times were, "Who am I apart from my functions in life?" , "What is happening to me? I feel like I'm falling apart?" "I am so alone, with nowhere to turn." Another line of comments went this way: "I turned my back on God", or "God let me down when my child died. I prayed so hard and my little baby still died;" or "I don't know where God is or how to talk to him." "I've been so bad not even God would want to care for me." With each of these heart-rending statements, the chaplain student would gently listen and encourage the patient with patience and often guidance in how to speak with God. Invariably, the next step the student would plan for was a follow up conversation the next day. However, with the short hospital stays, the next day the patient would be discharged to home with no possibility for follow up. The following challenge statement arose out of this vacuum, with the hope that follow up conversations on the phone would make a positive contribution to the spiritual grounding of the patient.

CHALLENGE STATEMENT

When hospitalized, people who are not connected to a faith community can struggle to find meaning and comfort in their lives. A pastoral encounter with a chaplain may facilitate their reconnection with their inner spirit. CPE students and chaplains will continue telephone contact with such patients when discharged from the hospitals within the Catholic Health Services in order to serve as a bridge that facilitates the discovery of or reconnection to a spiritual support network within the community.

CHAPTER 1

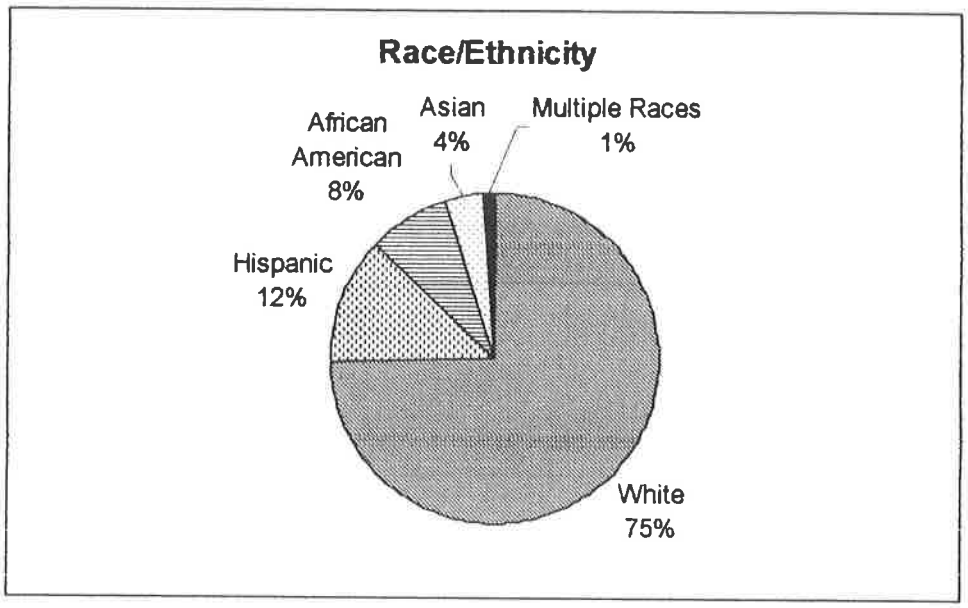
THE SETTING

General Setting: Long Island, New York

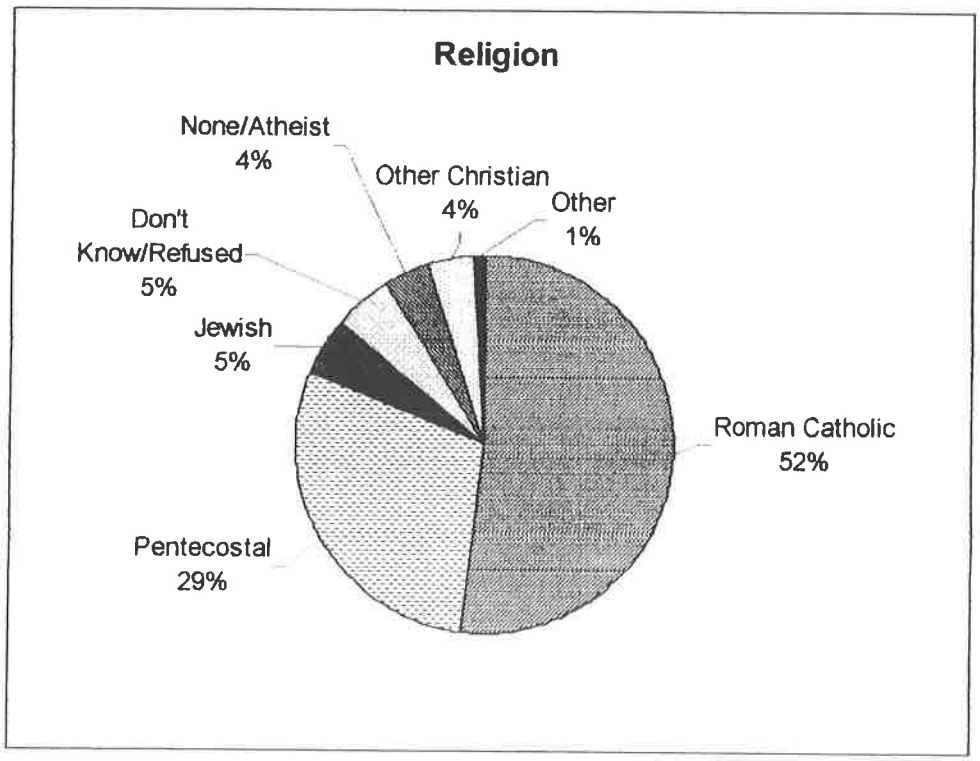
Long Island is the largest island adjoining the continental US, extending approximately 118 miles east-northeast from the mouth of the Hudson River. It is separated from the mainland on the north by the Long Island Sound and on the south and east by the Atlantic Ocean. Technically, Long Island has four counties, two of which are Brooklyn and Queens, within the boroughs of New York City. Nassau (287 square miles) and Suffolk (911 square miles) counties, however, are what people think of when they hear "Long Island."

The number of households in 2004 in Nassau and Suffolk is close to one million. During the summer, Suffolk, with its large inventory of seasonal units and second homes, experiences a large influx of visitors. This brings a dramatic increase in households as well as population. It also contributes to increased accidents and emergency room visits. The Long Island population estimates are 2.8 million, and account for 15% of the New York State population[1].

[1] "Long Island Index 2005," www.longislandindex.org/ (accessed March 2006).



Demographics of Race and Ethnicity on Long Island, NY



Demographics of religious affiliations on Long Island, NY

The population is changing, rapidly aging, and becoming more diverse with fast growth of Hispanic and Asian immigrants. Racial and ethnic segregation continues, and there is also an increasing geographic separation by age and income. There is a large number of undocumented Spanish-speaking migrant workers.

Healthcare is the largest industry cluster on Long Island and accounts for 12% of employment. The rate of ambulatory care hospital discharges with sensitive conditions (infections, asthma, high blood pressure, diabetes) has increased by almost 13% since 1997. A persistently high rate has been observed in Nassau/Suffolk communities, potentially indicating a lack of access to primary care by residents in these communities. These differences tend to be associated with socioeconomic status. Catholic Health Services of Long Island is the largest health system on the Island.

Specific Setting: Catholic Health Services of Long Island

Since 1913, the Catholic Church on Long Island has operated community hospitals and human service organizations distinguished for their compassionate, high quality care. The Roman Catholic Diocese of Rockville Centre's health care ministry, organized under Catholic Health Services of Long Island (CHS), brings its tradition of health and healing to thousands of persons in communities across Nassau and Suffolk counties.

CHS is comprised of five hospitals, three nursing homes, a regional home care program, a Hospice network, and a community based agency for persons with special needs. More than 14,000 staff and close to 3,000 medical professionals work within the CHS System. While the organization of these entities under CHS form an integrated

continuum of care, they remain distinct organizations with individual histories and distinct personalities that reflect the communities they serve. In addition, CHS operates out of a strong Gospel based mission and is intentionally committed to care for those who are poor, uninsured and medically underserved.

Under the leadership of a board of trustees that guides activities and sets policy, CHS works to transform Long Island's Catholic hospitals and related organizations into an effective, community focused delivery system. At the same time, CHS encourages each of the members to retain their link to history and their service specialties, which have positioned each member to serve its unique community. Within the system, member organizations offer virtually every medical specialty and clinical service, and share a dedication to continuously upgrading the scope, quality and accessibility of care.

Catholic Health Services has a strong, geographically diverse organization with a rich array of services that will continue to be a leader in providing high quality compassionate care. The active presence of vibrant pastoral care department in all hospitals is a strong value. Four years ago CHS received accreditation for its CPE program to offer training for chaplains and supervisors. This program is multicultural and interfaith, and students are trained to minister to persons of all faiths, as well as to those who do not profess any religious affiliation. Chaplains visit patients as part of their routine, and participate in the interdisciplinary activities of the patient care team. A consistent challenge, both to patients and also to chaplains, is the brief length of hospital stay and the discharge of patients while they may still remain vulnerable on many levels.

Focus Setting: The Patient Population

The specific settings for this demonstration project was in three areas, each meeting one of the project goals. The first was at the bedside of the patient about to be discharged. At this time the chaplain ascertained the patient's willingness to participate in this study. This assumed that the patient was at least curious about his or her own inner spiritual core and wished to have the assistance of a chaplain over a four week-period for follow-up discussion.[2]

The second focus was the weekly follow-up telephone conversations over four weeks. Their purpose was to keep alive the connection with the patient's spiritual core that was begun in the hospital. Chaplains had access to a database of spiritual resources and assisted the patient in accessing a source of spiritual nurture.[3]

The third focus area was the preparation of a database of Churches, Synagogues, Mosques, Places of Interfaith worship, web sites that offer prayer and support, local support groups for particular needs, retreats, and inspirational quotes and poems. Discharged patients could choose to initiate their own connection or reconnection with a community of worship.[4] However, as the research got underway, the goal for this resource document shifted to referencing where the information could be accessed, rather than reprinting the rather extensive list of worshipping communities on Long Island.

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[2] This pastoral encounter is to meet Goal 1, and the plan to identify patients and receive their consent for follow-up.

[3] This corresponds to goals II and III of the demonstration project. See pp. 12, 13.

[4] This corresponds to Goal III of the demonstration project. It is inclusive of multiple traditions and spiritual resources. It reference where more information about a particular religious community may be found.

CHAPTER 2

ANALYSIS OF THE CHALLENGE

The target concerns for this project are patients who find themselves hospitalized and describe themselves as "not spiritual." They are not connected to their own inner spirit and have little or no sense of community of support. They seem to suffer because they see no way to get through this difficult and challenging time of illness.

The active presence of vibrant pastoral care departments in all the CHS facilities is a testimony to the value placed in spiritual care of patients. While a very large percentage of the population of Long Island, as indicated in the General Setting, is Roman Catholic, the patients in the beds are from all faiths and pastoral care is offered to patients of all faiths and of no faith. However, the religious identity of the patient does not presume that the person is actively involved with a community of worship.

The American Religious Identification Survey (ARIS)[5] identified very significant shifts in the religious demographics of the continental US. A summary of the 2001 findings includes:

- The proportion of the population that can be classified as Christian has declined from 86% in 1990 to 77% in 2001.

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[5] "Demographics Of The United States - Wikipedia, The Free Encyclopedia," http://en.wikipedia.org/wiki/Demographics_of_the_United_States; http://www.gc.cuny.edu/faculty/research_briefs/aris/key_findings.htm. (accessed August 28, 2006).

- The number of adults who classify themselves in non-Christian groups has risen from 5.8 million to about 7.7 million, but the proportion of non-Christians has increased only about 3.7%.
- Greatest percentage increase has been among those who do not subscribe to any religious identification; this number has more than doubled from 14.3 million in 1990 to 29.4 million in 2001; their proportion has grown from 8% of the total in 1990 to over 14% in 2001.
- There is substantial increase in adults who refused to reply to the question of affiliation, from about 4 million (2%) in 1990 to more than eleven million (over 5%) in 2001.

Other interesting findings, relative to this project:

- Nearly 20% of those who describe themselves as atheist or agnostic also report that either they themselves or someone in their household is a member of a religious institution;
- Conversely, nearly 40% of respondents who identified with a religion indicated that neither they nor anyone in their household belonged to a religious institution.
- Women are more likely than men to describe themselves as religious, as are older Americans, in general. Black Americans are least likely to describe themselves as secular; Asian Americans are most likely to do so.

While these numbers are for the entire continental US, they are likely fairly reflective of the responses one might get from the residents of Long Island. These statistics give some idea of the challenge in identifying the patients for this project. It cannot be assumed that if someone is affiliated with a religious institution or place of

worship that they actually participate on any regular basis. Nor can it be assumed that if someone says he or she is non-religious, that this means there is no spiritual awareness.

An additional important fact is that there is an increase in the number of people who are not affiliated with any formal religious group. This does not, of course, mean that they do not have a developed spirituality that informs their lives and their worldview. "Worldview" is defined as "the overall perspective from which one sees and interprets the world" and "a collection of beliefs about life and the universe held by an individual or a group."[6]

Obviously, persons' worldviews will influence how they cope with illness. This project targets persons whose worldview does not include inner self-awareness, and whose basic assumptions and images do not involve any source of strength or energy beyond the purely external and physical realm. It is often empty of any reference to a deity or a supreme being. Nonetheless, the person may be quite interested in discussing religion and may not necessarily be hostile to religion. In general, a non-religious worldview does not include supernatural understanding, whereas a religious worldview often embraces belief in a supernatural being who is involved with humanity as creator, sustainer, judge or friend, to name just a few of the varied roles. [7]

The pivotal question may be, "What sustains persons in difficult times of illness?" Do they have any sense that there is some creative force that can actively shoulder this yoke of illness with them and give them strength they doubt they possess on their own?

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[6] *The American Heritage Dictionary of the English Language*, 3rd ed., "Worldview." Also at http://www.teachingaboutreligion.org/WorldviewDiversity/wvdiversity.htm, Accessed August 20, 2006.

[7] Ibid

Any illness prompts people to look backward and forward, inward and outward. They review their lives and look to what the future will look like in light of this health crisis. They also look inward to assess its meaning; outward, to study similarity of experience with others. This is a process that is challenging to do for oneself, and it is a process that some may choose to avoid altogether. However, for those who have not given the time and attention to this kind of reflection, a helping companion can be a very significant bridge for them as they connect to the significance of this event. This is the person that may well benefit from the four-week follow up telephone conversations, given the fast rate of discharge from hospitals in this current health care world. Just as it is difficult to make this connection without a companion/guide, so also is it difficult to sustain this inner connection without some spiritual support network within the community. The resources available for suggestion and options will be varied, creative, with some traditional modes and some less traditional, and tailored to meet the individual's spiritual quest. This resource listing will be made available to the discharged patient and be available for discussion during the telephone follow-up conversations.

CHAPTER 3

GOALS AND METHODOLOGY

The goals for this study were outlined as follows:

I. Goal: Identify patients within the hospital, unaffiliated with any organized religion, who had a reconnection with their inner spirit during their stay.

1. Strategy: Identify patients who have had spiritual awakening and who are not connected to any religious or spiritual community.

   Objective: Approximately 80 patients will be identified by chaplains over a 10-week period.

2. Strategy: Seek consent to participate in the project from identified patients.

   Objective: To receive consent prior to discharge to follow up by phone from approximately 40 patients.

II. Goal: Provide spiritual support for patients who have agreed to participate in the project after they have been discharged.

1. Strategy : CPE students and Chaplains will meet with two patients prior to discharge each week and follow up with them for four weeks (total 8 patients per chaplain)

Objective: students/chaplains will document weekly pastoral phone conversations for 4 weeks to continue support.

2. Strategy: determine the effectiveness of telephoned pastoral interventions over a 4-week period.

   Objective: students and chaplains will keep records of each conversation and intervention with each discharged patient;

3. Strategy: to develop a plan/structure for the general content of the weekly telephone conversations and interventions.

   Objective: CPE Students and chaplains will give completed form to supervisor at end of each 4-week period

III Goal: Link discharged patients with/ refer to spiritual resources within their communities.

1. Strategy: Creation of database for referrals

   Objective: 30% of discharged patients will connect with some spiritual resource within the community.

The methodology used for this project employed all the elements for investigation, inclusive of experience, inquiry, understanding, formulating, reflecting, checking, passing of judgment and deciding the conclusions.[8] It is grounded, first of all, within the action/reflection model of training that the CPE students are experiencing. This model

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[8] Frederick E. Crowe, ed., *A Third Collection: Papers by Bernard J.F. Longergan, S.J* (New York: Paulist Press, 1985), 140-143.

trains them to reflect on their experience, explore the meaning and the significance of the pastoral encounter, and gain new insight from the reflection that will empower them to act differently in subsequent encounters. The next level is with the Chaplain/patient encounter within the hospital setting, where the interaction enables what Lonergan might describe as the attentive, intelligent, reasonable, and responsible operations of dynamic human subjects.[9] Bernard Lonergan (1904-1984) is a well known Jesuit Theologian from Canada who spent his life trying to develop a new method in theology that could "enlarge and perfect the old by means of the new."[10] He made the discovery and articulation of this new method his life's work. His philosophy and theology of God are rooted in the human experience of life which matures through reflection, understanding and integration of that experience.

Anton Boisen (1876-1965), the founder of CPE methodology, describes the patient/chaplain encounter as the study of "living human documents."[11] Boisen was an ordained minister and a person who struggled with mental illness that resulted in numerous hospitalizations. He felt a calling to "break down the dividing wall between religion and medicine"[12] and devoted his life to researching how crises in life open the way to creative possibilities.

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[9] Bernard Lonergan, S.J, *Collection: Papers by Bernard Lonergan, S.J* (New York: Herder and Herder, 1967), 130-132; 139-141.

[10] Bernard Lonergan, *Insight: A Study of Human Understanding* (Toronto: Posthumous Critical Edition University of Toronto Press, 1992), 768.

[11] Anton Boisen and Glenn H. Asquith, *Vision for a Little Known Country: A Boisen Reader* (Decatur, Ga.: Journal of Pastoral Care, Inc, 1992).

[12] ACPE History Corner, "1," *Association For Clinical Pastoral Education, Inc*, http://www.acpe.edu/cpehistory.htm (accessed September 9, 2006).

> I seek the basis of spiritual healing in the living human documents in all their complexity and in all their elusiveness and in the tested insights of the wise and noble of the past as well as of the present.[13]

Simply put, both Lonergan and Boisen describe a method of focusing on human experience; trying to understand that experience and formulating it as clearly as possible; trying to judge whether or not one's understanding of the experience is correct; and finally, making decisions based on one's judgment. In the CPE process, and in this study, the beginning point is the experience of the chaplain in the pastoral visit with the hospitalized patient. The chaplain's task is to help the patient hear and understand his or her experience of this illness and its meaning in his or her life at this time. The follow-up telephone calls enabled the patient to keep focus on the spiritual aspect of coping with the illness and recovery. The patients spoke of the benefits of speaking about the health issue and the comfort offered by the listening and caring ear of the chaplain. The interviewers, likewise, were impacted by the trust and openness of the patients to speak of the pain at the deep heart's core.

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[13] Anton Boisen, *The Exploration of the Inner World: A Study in Mental Disorder and Religious Experience* (New York: Harper & Brothers, 1936), 248-9.

CHAPTER 4

PLAN FOR IMPLEMENTATION AND EVALUATION

In order to establish a benchmark that reflects the actual experience of chaplains with patients who were not connected to their own spirituality, a questionnaire was prepared and e-mailed to 15 chaplains of Long Island.[14] They also received a sample questionnaire for their review and to ensure that the interview instrument layout was easy to understand and to complete. This test batch was sent out in the end of August and chaplains were asked to share the information with interested colleagues.

The responses will enable further clarification and refinement of the tool. Certain themes and variables will be identified. Interested chaplains will be identified and the new group of CPE residents will begin their training in mid-September. The instrument will be ready for the new group of CPE students and those chaplains who have expressed an interest in this project.

Education:

The next step in preparation was the education of the interviewers regarding the project and the expectations placed on them. The training session was planned in two venues on two different days, in order to accommodate as many as possible and to facilitate engagement of chaplains. It was be based on models of adult learning,

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[14] See Appendix A for sample of pre-survey questions

particularly those advocated by bell hooks, in her book, *Teaching to Transgress: Education as the Practice of Freedom.*[15] Among the principles of her learning theory are the following:

- Each person has a contribution to make;
- Education should be exciting and meet the needs of those being taught;
- Education engages the teachers as well as the students in their own learning and growth;
- Reflection on experience is the tool that moves persons towards healing and wholeness;
- Sensitivity to inclusiveness and diversity means talking about these, hearing the differences, including the conflicts and discussing the conscious prejudices and bringing those that are unconscious into awareness.
- Education empowers students in their own context and setting;
- The teacher is a facilitator of what the students need to learn.

hooks' own words summarize her belief in the sacred task of education,

> That learning process comes easiest to those who teach who also believe that there is an aspect of our vocation that is sacred; who believe that our work is not to share information but to share in the intellectual and spiritual growth of our students. To teach in a manner that respects and cares for the souls of our students is essential if we are to provide the necessary conditions where learning can most deeply and intimately begin.[16]

This resonates with the very sacred task of the chaplain who must be respectful of where the patients are, what their needs are, and the mutual blessing of the encounter.

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[15] bell hooks, *Teaching to Transgress: Education as the Practice of Freedom* (New York: Routledge, 1994).

[16] Ibid., 13.

Participants in this educational process will include the eight current CPE residents, who begin their year-long program on September 13, and the experienced chaplains who have expressed interest in and enthusiasm for participating in the project.

The elements of this Educational curriculum are:

- Description of project
- Summary of feedback from preliminary questions to chaplains,
- Discussion of identification of specific patient population,
    - Patients with no religious affiliation,
    - Patients with affiliation but disconnected,
    - Patients who are not interested.
- Interview procedure with patients being discharged.
    - Consent forms
    - Gathering information
- Content and process for each follow up week
- Data collection:
    - Quantitative
    - Qualitative
- Database of resources that will be available for reference.
- Education of Discharge Planners

The Discharge Planners at the facilities will be educated by the chaplain doing the interviews about the project. They will be asked to assist in identifying patients who might be candidates for the study.

Once this was in place, I will meet with my site team to review the process and receive their input. This meeting will take place prior to the educational session for CPE students and chaplains.

Based on the feedback from the team and the participants, the research will begin by the end of September and continue through the end of December. Participants will be instructed to keep detailed notes on their pastoral conversations over the telephone. They will send me the report at the end of each four week period or sooner, if the discharged person either:

a. chooses to discontinue the conversation, or

b. connects with some resource for spiritual nurture after the second or third week.

EVALUATION PROCESS

1. The chaplains will offer their feedback on the survey instrument.
2. The education session with the CPE students and the chaplains doing the interviews will be evaluated regarding
    a. Helpfulness,
    b. clarity,
    c. level of enthusiasm among interviewers for the project,
    d. practical assistance.
3. The site team will serve as an oversight committee for the research.
4. The NYTS Advisor will be apprised of the progress and evaluation findings on a monthly basis.
5. I, as CPE supervisor, will be working with the CPE students each week.

The curriculum will have scheduled time to discuss the project and the experience of the students as they use the tool and work with the patients.

6. I will plan a teleconference with the chaplains who volunteered to be interviewers on a bi-weekly basis. However, I will be available to individuals if there is a need in between the planned teleconference.

7. I will have monthly meetings with the site team to report on the project. At these meetings we will assess the adequacy of the tool for the intended purposes. We will also carefully review the process for the telephone conversations that will be taking place concurrently.

   Adjustments will be made as required.

8. The site team will evaluate the process at the end of the research phase.

9. The site team will evaluate the quality of the work and assist in the study/evaluation of the research findings.

CHAPTER 5

MINISTERIAL COMPETENCIES

One of the disadvantages of the competency reporting was that the site visitors felt that I had a certain level of competency in all of the areas indicated on the form. In our discussion, there was mutual agreement that there was always room for growth in each of the areas identified. However, three areas of growth are singled out for improvement through the implementation and completion of this demonstration project:

COMPETENCY GOALS

1. Goal: to grow in awareness of my own cultural biases and to assist students in their growth in this area also.
    a. Objective: To minister with ever greater sensitivity to persons of all cultures, particularly those who participate in this demonstration project.
    b. Strategy: To intentionally include a discussion of cultural biases and issues in each discussion of CPE students' pastoral visits.

2. .Goal: to improve timeliness in follow through on plans relative to the demonstration project.
    c. Objective: to stay close to the steps of the project and to manage time and resources efficiently.
    d. Strategy: to use to monthly meetings of the site team to monitor and reflect on the steps of the plans and how these are being carried out.

3. Goal: To continue to grow in the skills of relating and communicating

e. Objective: Keep on top of the work of the students and chaplains and their weekly follow-up conversations with discharged patients.

f. Strategy: Plan time into the CPE schedule each week to talk about the project and their experiences with patients and families.

i. Also, connect by telephone or e-mail each week with the chaplains who are engaged in the follow-up telephone calls.

These competency goals will be monitored and evaluated at each of the monthly meetings with the Site Team, i.e., on October 16, November 13, and December 11.

. EVALUATION OF MINISTERIAL COMPETENCY GOALS

This entire process has been such a valuable learning experience, both for me and for those who participated in any way, including the site team members. The competency goals were evaluated at each site team meeting and this kept me moving forward and alert to their importance.

Goal 1:

Growth in awareness of my own cultural biases was a constant, because in this particular group of students there were four Roman Catholic priests from Africa, one from Tanzania and three from Nigeria. I intentionally encouraged them to make the connections between their cultural experience and what they experienced in New York. They identified American cultural values that were in conflict with their familial background. I was sensitive to the shifts they had to make in their sensibilities in order to

minister effectively in this culture. I asked two of the students to present a didactic on the cultural differences. In their presentation, they spoke of the particular issues of African men, and African priests, in particular. These included being "king" in their own village, and feeling less than "second class citizens" in this country, and in parish rectories where they reside. They also spoke of their enormous fear and distrust of the judicial system, along with so many elements that contributed to their discomfort and stress. In addition, the CPE process mode of learning was foreign to them, as was the expectation that they share their vulnerabilities as well as their strengths. This helped me be more sensitive to the magnitude of the cultural adjustments these men were experiencing. The discussions were enriching and productive for all of us.

Perhaps the most significant bias that was challenged during this project was the level of spiritual nurture and growth that actually takes place outside the traditional religious worship setting. I know many persons who have a difficult time with the institutional forms of spiritual growth and development, and I know them to be people who do value their own inner life of the spirit and find intentional ways of enhancing nurture and growth. I somehow had an assumption that persons who came to the hospital and who were not affiliated with any worshipping community, would be spiritually impoverished. Without doubt, there are many who face their illness with emptiness and even desolation. However, this study showed that all of the patients who were interviewed and followed for four weeks had a moderate level of spiritual well-being. While it was a small sampling of patients, many reported talking with God and trusting that God was with them. This gave them hope and some level of peace. Perhaps asking persons if they are observant is not the question we ought to focus on, but rather, how do

they reflect on and care for their own soul. What are the meaningful relationships and values that are important to them? What helps them find meaning, direction and purpose? We need to cease trying to impose the structures that speak to us, but may not speak to a vast number of non-religiously affiliated human beings. I feel that this study has helped me change my mentality about non affiliated persons and reflect more on what truly nurtures my own soul, and at the same time, do some self examination about my motives for my own participation.

Goals 2 and 3:

Timeliness was a concern with the project implementation because of the need to move forward rather quickly from the time the proposal was approved to the actual completion of the study. This was somewhat complicated by the fact that I was away for conferences. The CPE unit ended for the residents in the middle of December and the following six weeks for them were full time patient care with no group gatherings. This presented a positive result because the students had more time with patients. The down side of that was that the weekly class and peer group interactions did not take place, nor did the weekly monitoring of the individual studies. The two certified chaplains who were identifying and following up with patients were highly motivated and invested in the study. We communicated via e-mail and telephone. These communiqués were meaningful, even if not regular. I felt this was a project that could not be left on the back burner, in terms of time. Also, I was committed to ensuring that the patients were followed by telephone, as promised to them. I learned that I could trust those who were doing the identifying and the follow-up, and that they were mature enough to seek me out

with questions. The site team members were also very supportive and the meetings with them kept me focused and on track with the forward movement of the study.

CHAPTER 6

BIBLICAL EXEGESIS

How do humans endure illness, injury, life-threatening disease and the prospect of immanent death? To some, those affiliated with organized religion may seem to have an "edge" on coping with such life-changing events. At best, they profess recognizing and having faith-based sensibilities. When their stay in hospital is over, they return to the neighborhood in which they live and to the community or congregation with whom they pray and enjoy fellowship. On the other hand, hospitals increasingly are becoming more populated with people who claim to have no formal religious affiliation. To what do they refer or turn to in such times, and to what do they return upon discharge from hospital?

Answers to that multi-tiered question have informed my project in many ways. First, Matthew 11:28-30 will be offered as invitation to those who labor under the rigors of such life-changing events as listed above. Second, I will explore some theological considerations of what it is to be "heavily laden," to suffer. Finally, I will outline how both inform my project.

The Scripture passage that readily comes to mind when I think of those who are heavy laden with illness and do not know where to turn for help and support is in Matthew 11:28-30:

> Come to me all who labor and are heavy laden, and I will give you rest. Take my yoke upon you, and learn from me, for I am gentle and lowly in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light.

This passage is unique to Matthew's gospel which was written in the last quarter of the first century CE.[17] To understand the setting, it is important to look at what precedes these verses in chapter 11.

Early in the chapter Jesus is speaking to the crowds about John the Baptist. John was born in the Judean Hills (Luke 1:39), and he is a cousin of Jesus. Luke's Gospel notes many parallels to the call of Jeremiah: John was consecrated before birth (Jer.1:3, Lk.1:13), and he announces the Messiah (Jer. 31; Lk. 1:14). John chose to live in austerity and to call for repentance and conversion of heart. He baptized in the Jordan River and his was a baptism of water, in preparation for the baptism in the Spirit that Jesus would proclaim.

Jesus witnesses to John's life style and to his prophetic mission (Matt.11:9).[18] Jesus refers to Mal. 3:1 as he describes John:

> Behold, I send you my messenger to prepare the way before me, and the Lord whom you seek will suddenly come to his temple; the messenger of the covenant in whom you delight, behold, he is coming, says the Lord of hosts.

John is the last and the greatest of the prophets but because he is before Jesus, even he can do less than those who come after God's reign which is established in the person of Jesus. John lived a hermit's life and surrounded himself with the minimum to survive. Jesus did not assume this way of life, but he was on the side of the poor and the

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[17] Barton, John and Muddiman, John, eds., *The Oxford Biblical Commentary* (New York: Oxford University Press, Inc, 2001), 845.

[18] Raymond F. Brown, James A.Fitzmyer, SJ and Roland E. Murphy, O.Carm, eds., *The Jerome Biblical Commentary* (Englewood Cliffs, NJ: Prentice Hall, 1968), Vol 2, 43.75.

oppressed. Neither life style was acceptable to the establishment because it called for a change in the status quo.[19]

However, John would have been popular among the poor and oppressed. As Jesus addresses the crowd, John is elsewhere in prison, but many of the listeners to Jesus may also have flocked to the wilderness to hear John. It may be fair to suggest that people were drawn to him, as they were to Jesus, because of his simplicity, his genuineness and his message. John was the first "prophet" since Elijah, the first one who spoke of God in more than four hundred years. The people were searching for meaning beyond the world around them and John met their need.

Such soul searching has parallels with the current focus of this project: people who are distanced from their sense of meaning and purpose in life and who, when confronted with an illness, wonder where to find meaning and sustenance in trying times. What worked well when they were healthy and busy, does not work so effectively when they are hospitalized and immobilized by illness. In the text, people were attracted to John because of his separation from the idolatries of the times, and the purification he had undergone in his desert experience. People who suffer illnesses and hardships enter a desert of sorts. They are stripped of the things that define who they are: their possessions, their positions, their external displays of power and authority. How can they find solace and meaning beyond the material entrapments of this world? Who will be there to refresh their souls? Who will help them hear the message, "Come to me...."?

Following his defense and praise of John, Jesus utters some woes about those cities that did not follow through on their good actions and either rejected the message, or

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[19] Ibid

just did not get it (Mt.11: 20-24). In spite of what they had witnessed, they were moved by and disinterested in the message of Jesus.

As this chapter moves forward, Jesus somewhat abruptly shifts his attention and speaks his thanks directly to his Father (11:25-27). His prayer identifies those who are humble and can hear the word. The Pharisees, in their pride and intellectual superiority, could not hear the word and fought against it. The word is revealed to the little ones, those of simple trusting faith, the followers of Jesus, rather than the wise and prudent spiritual leaders and scribes.[20] The words of Jesus to his Father show a relationship that is one of trust, intimacy and childlike simplicity.

This leads right into the passage under consideration for the purposes of this project. "Come to me...." seems to be a passage preparing for the following chapter in which Jesus is highly critical of the Pharisees and the burdens and interpretations of the law that they place on the common people. They weigh them down with legalistic yoke. The Pharisees wanted to impose their more than 600 rules and regulations on others, and so religion became a heavy burden to carry. The yoke that Jesus offers is entirely different: it is easy, it is light. It does not eliminate the burdens of life or even encourage disregard for the law. It invites relationship with him. Support, learning and relief from burden are the results of this relationship of friendship and empowerment.

The yoke imposed by the Pharisees is the harsh, negative and heavy burden from the rules and regulations that they demand that people follow. The yoke of Jesus is love of God and love of neighbor. The message of Jesus challenges and criticizes that of the Pharisees. At certain times the interpretation that Jesus gives the law is far more lenient

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[20] Ibid., 83

(observance of Sabbath, curing the blind, healing the sick, etc.) and Jesus places emphasis on justice, mercy and faithfulness, along with the commandment of love.[21] He is harsh in his criticism of those who feed themselves but exploit the poor, those who do not bind up the wounds of the injured or who use the law to justify not assisting the needy.[22]

Jesus, who is gentle and humble, invites us to find rest in him, to find in him that place of healing, and renewed strength for the burden of the moment. Many Biblical scholars remind us that Jesus was a carpenter, and that he may have known how to craft the yoke for the oxen in such a way that it wore easily and almost effortlessly. This is what would have made it both easy and light, as opposed to a yoke that was ill fitting. The Pharisees crafted ill-fitting yoke for the people. Jesus lifts us up and holds his people when the burdens of life are heavy. Jesus promises to shoulder their burden with them and his word is trustworthy. The invitation of Jesus is very personal: "Come to ME all who labor and are heavy laden." The word "labor" is sometimes translated as "weary," whose Greek translation generally means, "to be engaged in hard work,"[23] and the result of the hard work is fatigue. It also means, "to become emotionally fatigued and discouraged, to give up, to lose heart,"[24] feelings that are familiar to persons who face a health crisis. Feelings of

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[21] Douglas R.S Hare, *Interpretation: Matthew* (Louisville: John Knox Press, 1993), 128-129.

[22] Warren Carter, *Matthew and Empire: Initial Explorations* (Harrisburg, PA: Trinity Press International, 2001), 117.

[23] Ibid., 115.

[24] Ibid..

discouragement, loss, isolation are common for those who are hospitalized and whose lives are interrupted by illness. "And you will find rest (anapausin) for your souls." Anapausin denotes a temporary rest, a respite, e.g., of soldiers, the kind of rest that offers refreshment for the work ahead, along with purpose, meaning and vision.

Historical and Socio-Economic Analysis

Matthew, the author of this gospel, appears to be the same tax collector referred to in Mt. 9:9-13, and the person listed in the call of the Twelve[25]. Matthew was a Jew and used several Jewish features that imply a Jewish Christian author and audience. Matthew's theology was Jewish theology, and his God was the God of the Hebrew Testament, the God of Israel.[26] His moral teaching was the teaching of love, the call to non-retaliation, and the imperative to follow Jesus, all features common to early Christian discipleship.[27] Matthew sees Jesus as the Messiah of the Old Testament, and therefore, it is his task to reinterpret the Law, which is the basis of Judaism. In Matthew, Jesus proclaims the yoke of God's reign, rather than the yoke of the Law. God's yoke is the command of love.

Regarding the particular text, Matt. 11: 28-39, there is much divergence of opinion about its origin, its audience and the nature of the promise that is offered.[28] One view put

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[25] Raymond Brown, Joseph A. Fitzmyer, SJ and Roland Murphy, O.Carm, eds., *The Jerome Biblical Commentary* (Englewood Cliffs, NJ: Prentice Hall, Inc, 1968), Vol 2, 65.

[26] John Barton and John Muddiman, eds., *The Oxford Bible Commentary* (New York: Oxford University Press, Inc, 2001), 845,846.

[27] Ibid.

[28] Warren Carter, *Matthew and the Empire: Initial Explorations* (Harrisburg, Pa: Trinity Press International, 2001), 108.

forth by M. Jack Suggs in 1970,[29] and elaborated on more recently by Cecilia Deutsch (1990's),[30] asserts that Jesus speaks as a Wisdom figure to people burdened down with the demands placed on them. They indicate that this passage must be read along with Sirach 51:26-27:

> Put your neck under the yoke,
> And let your souls receive instruction;
> it is to be found close by.
> See with your eyes that I have labored little
> And found for myself much rest.

Others disagree and feel that the links with this passage are insignificant, as are links with Jesus as a Wisdom figure. They take the passage more at face value and see Jesus calling his disciples and promising to be with them in their mission.[31] Two other Matthew scholars, William Davies and Dale Allison agree that Jesus may be a Wisdom figure, but identify him with Moses. They point to the intimate relationship between God and Moses and to God's promise of rest.

In Exodus 33:12-14,

> Moses said to the Lord, "see, thou sayest to me, 'Bring up this people'; but thou hast not let me know whom thou wilt send with me. Yet thou hast said, ' I know you by name, and you have also found favor in my sight.' Now, therefore, I pray thee if I have found favor in thy sight, show me now thy ways, that I may know thee and find favor in thy sight. Consider, too, that this nation is thy people. And he said, "My presence will go with you, and I will give you rest."

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[29] As cited in Carter, 108. M. Jack Suggs, *Wisdom, Christology and the Law in Matthew's Gospel* (Cambridge: Harvard University Press, 1970), referenced in Carter, 108.

[30] As cited in Carter, 108. Celia Deutsch, *Lady Wisdom, Jesus and the Sages: Metaphor and Social Context in Matthew's Gospel* (Valley Forge, Pa.: Trinity Press International, 1996).

[31] As cited in Carter, 109. Graham Stranton, *A Gospel for a New People: Studies in Matthew* (Edinborough: T. & T. Clark, 1992), 370-1.

They see Jesus as offering his presence and rest to all those who give themselves to his work, disciples and non-disciples alike. Jesus has status as the new Moses of the New Covenant.[32]

Blaine Charette[33] takes a different approach and sees this passage as the promise of Jesus to free Israel from the foreign oppression that burdened them. He sees Jesus as the Messiah who has come to set captives free. He calls them back to God's service and promises relief and rest in God's service. Russell Pregeant[34] also sees Jesus as the Messiah who calls non-disciples to take up the yoke of God. Frances Taylor Gench[35] argues that Jesus is the Son of God who imparts authentic understanding of Torah, reveals the true nature of God and promises to be with his disciples as they follow this law.

Warren Carter builds on each of the above scholars and argues that the Jesus who proclaims himself as Son of God, the one who speaks for God, invites the people to take on the reign of God in this time with the promise that this is what will destroy all empires, including Rome's.[36] Jesus calls people into personal relationship ("Come to ME") and promises a personal relationship with them as they follow.

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[32] John Barton and John Muddiman, eds., *The Oxford Bible Commentary* (New York: Oxford University Press, Inc, 2001), 860.

[33] As cited in Carter, 109. Blaine Charette, "To Proclaim Liberty to the Captives: Matt.28:30 in the Light of OT Prophetic Expectation"" *New Testament Studies* 38 (1992).

[34] Russell Pregeant, *Matthew* (St. Louis, Mo.: Chalice Press, 2004), 80.

[35] As cited in Carter, 110. Frances T. Gench, *Wisdom in the Christology of Matthew* (Lanham, Md.: University Press of America, 1997), 91-135.

[36] Carter, 112.

In Sirach 24: 19, we hear similar words spoken by Wisdom personified: "Come to me, you who desire me, and eat your fill of my produce". Likewise, in the last chapter of Sirach, 51:23, we read, "Draw near to me, you who are untaught, and lodge in my school." This is in stark contrast to the Roman imperialist regime of Matthew's time which was oppressive and caused people to live under severe economic repression. It was a time of great social inequality, with a small elite of less than 5%, who exercised political, economic and social control over the majority who were poor and downtrodden.[37]

Rome made demands, as did the tax collectors and those who forced labor and posed threats for non-compliance. It was a world of imperial power with its opulence, injustice and total lack of any consideration for those who strove desperately to survive. Jesus is aware of his audience. He rejects this regime later in Matthew's gospel when he says, "You know that the rulers of the gentiles lord it over them, and their great ones are tyrants over them. It will not be so among you..."(Matt. 20:25-26).

Jesus invites them to "Come to me all who labor and are heavy burdened," those who are oppressed, heavily taxed, and burdened down with adherence to the rigid letter of the law. These people know the weary labor of their imperially dominated society. Jesus calls them to a different kind of laboring – to laboring in a world ordained according to God's purposes, a world diametrically opposed to the imperially dominated one of the Matthew audience.

The Pharisees, the religious leaders of the time, supported the status quo and were likewise oppressors. Jesus does not condemn them for their adherence to the law or their

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[37] Ibid., 114.

imposition of the many laws on the backs of the people. Rather, as Carter points out, Jesus opposes them because of their failure to be concerned about God's will of "justice and mercy and faith."[38] There are numerous scenes where the Pharisees oppose Jesus for his acts of mercy, forgiveness and healing (Mt 9:13, 12:7). Their opposing vision of society causes repeated clashes and judgments on both sides.[39] Jesus disqualifies the ruling bodies of Jerusalem and Rome when he identifies the people with "sheep without a shepherd" (Matt. 9:36).[40] The local leadership, priests and scribes included, aligned themselves with the aristocracy and upheld the status quo imposed by Rome.

It is to these struggling people that Jesus speaks when he says, "come to me" and he promises them "rest for your souls." The rest that he promises does not mean non-work, nor does it mean idling. Rather it means the rest that comes from being in right relationship with God's purposes and plan for all. It is the rest that Jeremiah speaks of when he says in 6:16, "Stand by the roads, and look, and ask for the ancient paths, where the good way is; and walk in it, and find rest for your souls."

"Take my yoke and learn from me" would have been familiar language to the listeners. The word "Yoke" is found sixty three times in the Septuagint, and predominantly these references have to do with control. It is a rabbinic metaphor for the difficult but righteous task of following Torah. It is fair to assume that the hearers of the word were under harsh imperial control and were both oppressed and exploited. Acts

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[38] Ibid., 117.

[39] For example, Mt.16:12 reads "Beware of the leaven of the Pharisees and Sadducees" and Mt. 9:34 quotes the opposing sides' view: "but the Pharisees said, 'he casts out demons by the prince of demons.'"

[40] Ibid.

15:10 speaks of the injustices of the yoke placed on people: "Now therefore, why do you make trial of God by putting a yoke upon the neck of the disciples which neither our fathers nor we have been able to bear?" God is on the side of the oppressed and delivers and liberates people from the yoke of the oppressors.[41] In chapter 22:7, Matthew interprets the destruction by Rome of Jerusalem in 70 C.E. as punishment for the sins of rejecting the message of Jesus: "the king was angry and he sent his troops and destroyed those murderers and burned their city."[42]

By contrast, the yoke of God is easy and kind. God is also just and merciful (2Macc. 1:24); ready to forgive and merciful (Ps 86:5); compassionate (Ps. 145:9); exhibits steadfast love and mercy that lasts forever (Deut 4:11; 5:22).[43] Carter identifies that in three of its seven uses in the New Testament, the word "yoke" refers to the goodness or kindness of God.[44] The yoke that Jesus offers is the antithesis of the oppressive, exploitative, intimidating and unjust yoke of the imperial yoke of Rome. It is life giving and just (Matt. 7:13-14). It invites people to live and hope for an alternative life style in the midst of their current situation, a life style of service to and love for one another.

Jesus, the leader of this new life, is "gentle and humble of heart," in dire contrast to the Pharisees and scribes who surround the people and lean on them with demanding arrogance. This is a gracious Jesus who offers a gentle and loving call to all who labor

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[41] Ibid., 125.

[42] Ibid.

[43] Ibid., 126.

[44] Ibid.

and are burdened, a Jesus in whom they find a promise of an easy, shared yoke and with rest for their souls. According to Pregeant,[45] the term "gentle" means not just those who are humble, but also the humiliated, the oppressed. "To say that Jesus is 'gentle and humble of heart' means not simply that he is nonviolent but also that he takes his stand in solidarity with all those of marginalized status in society."[46]

To the diversity of opinions already cited regarding Matthew 11, I posit this consideration. It should be noted that, of the four Gospel writers, it is Matthew who refers to the prophet Isaiah most often.[47] Throughout his Gospel, Matthew frequently demonstrates how Christ became the fulfillment of Isaiah's messianic prophecies. Again, the "yoke" motif can be seen in Isaiah 58:6-12:

> This, rather, is the fasting that I wish:
> Releasing those bound unjustly,
> Untying the thongs of the yoke;
> Setting free the oppressed,
> Breaking every yoke;
> Sharing your bread with the hungry,
> Sheltering the oppressed and the homeless;
> Clothing the naked when you see them,
> And not turning your back on your own.
> Then your light shall break forth like the dawn,
> And your wound shall quickly be healed;
> Your vindication shall go before you,
> And the glory of the Lord shall be your rear guard.
> Then shall you call, and the Lord will answer,
> You shall cry for help and he will say:
> Here I am! If you remove from your midst
> Oppression, false accusation and malicious speech;

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[45] Pregeant, 82.

[46] Ibid.

[47] Matthew refers to Isaiah ten times: Mt. 1:23-23; 3:3; 4:14-16; 8:17; 11:5; 12:17-21; 13: 14-15, which refers to Isaiah 6:9-10 on how the people were not receiving God's message; Mt. 15:8-9, referencing hypocrisy from Is. 29:1-3; Mt. 21:24-29.

If you bestow your bread on the hungry and satisfy the afflicted;
Then light shall rise for you in darkness,
and the gloom shall become for you like midday;
Then the Lord will guide you always and give you plenty even on parched land.
He will renew your strength and you shall be like a watered garden,
Like a spring whose water never fails.
The ancient ruins shall be rebuilt for your sake,
And the foundations from ages past you shall raise up;
"Repairer of the breach," they shall call you, "Restorer of ruined homesteads."[48]

It is the Christ of Matthew 11: 28-30 who is the fulfillment of this passage. Unlike the burdensome yoke of 600 laws laid upon the shoulders of the people by the Pharisees, Christ's is a yoke made easy by love: love God and love your neighbor. Do these things for others and you will be lifted out of gloom, your own wounds will be healed, you will be renewed, and you will find rest. Christ's yoke shifts the weight of legalistic imperatives that "guarantee" heaven for the individual, perhaps even at the neglect and peril of others, to an altruistic one that is fiercely attentive to human flourishing and the subsequent removal of all obstacles to it. This is a very different yoke or "law," indeed; one that Jesus invites the listener to learn from him.

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[48] *New American Bible*, (Washington, DC: Confraternity of Christian Doctrine, Inc, 1991).

CHAPTER 7

THEOLOGICAL RESEARCH AND ANALYSIS

In his 1984 Apostolic Letter on suffering, *Salvifici Doloris*, John Paul II describes various kinds of suffering found throughout the books of the Old Testament: the danger of death; the death of one's own children; the lack of offspring; nostalgia for the homeland; persecution and hostility of the environment; mockery and scorn of the one who suffers; loneliness and abandonment; the remorse of conscience; the difficulty of understanding why the wicked prosper and the just suffer; the unfaithfulness and ingratitude of friends and neighbors; and finally, the misfortunes of one's own nation.[49] To be sure, any one of those sources of suffering would bend the human spirit. It is during such critical moments in life that, at long last, our undivided attention to life and its meaning has been won. Reluctant student to the powerful lessons available for discovery, one begins scrutinizing this change in life-as-usual with typical queries: "How did this happen?" "Why?" "What will become of me?" "What means my life now?"

For some, those questions reverberate off of decades of religious formation, spiritual development and interior maturity. Not spared the struggle of the search for answers, religiously oriented persons are, nonetheless, somewhat equipped for it. For

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[49] Pope John Paul II, *The World of Human Suffering* (Rome: Libreria Editrice Vaticana, 1984), Section 6, as from Salvifici Doloris: the Apostolic letter of the Supreme Pontiff John Paul II to the Bishops, to the Priests, to the Religious Families and to the Faithful of the Catholic Church on the Christian meaning of Human Suffering.

others, however, such questions are met with the "thud" of spiritual neglect, disinterest or disregard.

Bernard Lonergan viewed such disregard for one's own self-transcendence as "alienation."[50] The practiced avoidance of taking life experiences to richer soil through reflection, discovery, assimilation and change is discovered to have borne no fruit. The fullness of what it is to be human has withered from such inattentiveness. In the heat of crisis, the sudden thirst for meaning can barely be quenched. Alienation from one's true, authentic self is the product.

Lonergan also identifies the disregard of one's feelings as another form of alienation.[51] How does one grow, mature without acknowledgment and recognition of one's own feelings? Living life in a blur of shallowness and distraction from one's true feelings, a person becomes ever the stranger to oneself, surprised by one's own reactions and behaviors, as well as their impacts on others.

Negative value is an additional form of alienation. This negation may manifest itself as an estrangement of the human from the human world. Displacement is experienced when the social fabric of one's world is alien to a specific manifestation of being human. The sense of the loss of order within a person can be added to this negation of value.

The negation of ethical value shows itself in drifting, in making no choices at all. One finds it easier to conform, to let others make all the decisions. The litany is familiar:

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[50] Bernard Lonergan, *Method in Theology* (New York: Herder and Herder, 1972) 55

[51] Ibid., 34.

"Oh well..." "So what..." "Whatever..." This abdication of responsibility opens the door to indiscriminate power manipulators. When there is the negation of religious value, God is no longer in the horizon, secularism reigns, sin is fun, and there is full assertion of the petty self. This eclipse gives birth to illusion regarding human capabilities, or despair in the face of disillusion.[52]

Hence, such disregard for one's own self-transcendence proves particularly problematic when faced with a life-changing crisis and leaves one feeling alienated from one's true self. Lonergan describes this alienation as the basic human disregard of the transcendental precepts: Be attentive; Be intelligent; Be reasonable; Be responsible. If necessary, change.[53] This precarious and ever-developing state depends on long and sustained faithfulness to those transcendental precepts. Providing opportunities for such sustained faithfulness to those transcendental precepts is precisely the task of this project; its goal is the promotion of interior maturity, of discovering or rediscovering how and where meaning emerges through the language of prayer and relation to divinity.

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[52] Bernard Lonergan. *Topics in Education: Collected Works of Bernard Lonergan* 10 (Toronto: University of Toronto Press, 1993), 46

[53] Bernard Lonergan, *Methods in Theology* (New York: Herder and Herder, 1972), 55.

CHAPTER 8

BIBLICAL AND THEOLOGICAL APPLICATION TO THE PROJECT

Matt. 11:28-30 is perhaps one of the most popular passages of Matthew's gospel. For persons who are hospitalized and needing solace, there are connections on so many levels with this passage. On occasion, patients hear this passage and feel God's absence, rather than comfort. They expect ready-made answers and magical interventions, and when these do not occur, they feel isolated and alienated. Even when physically vulnerable, it is often risky for some persons to let themselves be emotionally and spiritually vulnerable.

It may be helpful to look at this very meaningful passage, phrase by phrase, and reflect on its application to patients who may be disconnected or alienated from their own inner spirit:

"Come to me all who labor and are heavy laden"

Jesus, this teacher of the new law, is the one who wants the relationship and the intimacy with his people, a relationship of gentleness and trust, like his own relationship with his Father. The invitation is to ALL who labor and are heavily burdened. No one is omitted from this invitation and all are offered unconditional acceptance. Jesus is on the side of the oppressed, and is particularly attentive to struggle and hard work. Persons who struggle with illness, whether chronic or acute, whether they have a faith base or not, are frequently challenged to redefine who they are as they cope with the burden of illness. As they deal with their body's diminishment through illness, they come to a place where they cannot identify themselves by their possessions, or accomplishments, or job, or

social connections.[54] This demand is not lesser or greater for persons who do not have a community of support, but the invitation is there for all: "come to me all who labor and are heavy laden." For those who are connected to a faith community, they find solace and comfort in the midst of their burden through their community's rituals and support. It appears Jesus is longing for those who are disconnected to reconnect with the center of their being, their inner self, and the place where they connect to their own dignity and to their God. God invites them in this place so that they may find rest and solace and support in the challenges and burdens of life.

"And I will give you rest"

In many of the biblical references to "rest," the connotation has to do with a break from political upheaval, a reprieve from the battles and a replenishment of energies. Fatigue is almost always a component of illness and the concurrent stresses it harbors. The words used by patients to describe their illness often uses phrases like, "battling cancer", "waging war against this disease", "conquer the illness", "fighting the disease", all terms that speak of upheaval and aggressive action against the "enemy", which is the illness. What is the rest Jesus promises? For those who are disconnected from their own selves, the rest can come from entering their own inner center. It is a rest that comes from being in the moment, working with the body in its own efforts to regain health and homeostasis. It is the rest that comes from knowing that they are not alone, that there is energy and a strength (grace and blessing) available to them, and it is there at their disposal, waiting for their recognition and assent.

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[54] Verna Benner Carson and Harold G. Koenig, *Spiritual Caregiving: Healthcare as a Ministry* (Philadelphia: Templeton Foundation Press, 2004), 214.

"Take up my yoke and learn from me"

The "yoke" is the message of God, as well as an invitation to permit the assistance of something greater than self in shouldering the burden. This does not impose additional demands but rather, makes it easier to bear the burden that is already there. The word "learn" shares the same root as the word "disciple", which would assume that the learning happens through example, rather than through words.[55] Those who are weary are invited to a new form of learning, from the example of a teacher who is "gentle" and "humble in heart". As patients who are distanced from any form of spiritual nurture encounter a pastoral presence who shares their yoke, on behalf of Jesus, and who follow the gentle and meek example of their Master, there is hope that they will find something meaningful in the relationship that invites further exploration and learning. God, who is the source of all being, invites those who are of any faith, as well as those who are of no faith tradition. The desire of this Eternal Being is that persons feel they have a support and companion in their struggles. Even when they claim it from the "Universe" , this Divine energy is still real and available and ready for their assent to its empowerment.

"For I am meek and humble of heart"

The gentleness of Jesus is in contrast to the harshness and heartless attitude of the Pharisees. It suggests that Jesus is on the side of those who are humiliated, oppressed. To say that Jesus is "gentle and humble of heart" means not simply that he is nonviolent but also that he takes his stand in solidarity with all those of marginalized status in

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[55] Walter Brueggermann et al , *Texts For Preaching: A Lectionary Commentary Based on the NRSV Year A* (Louisville: Westminister John Knox Press, 1995), 396.

society.[56] Patients in hospitals often speak of how dehumanizing their care is and how diminished they feel by the invasiveness of technological interventions. They may even be humiliated and demeaned by the care given by overworked and stressed out staff persons. When the sense of self is so violated, Jesus promises support and comfort from a place of gentleness and humility Hopefully, this is the kind of presence the chaplain brings to the patient: a presence that helps the patient restore and/or reclaim his or her own sense of self dignity and respect. It is a presence that is humble and unobtrusive, gentle and attentive to what the patient needs, and willing to companion them in their struggle.

"And you will find rest for your soul"

This promise of Jesus is that they will find rest in their "soul", even as their body works hard to heal, or deteriorates towards death. People can find peace in the midst of struggle and illness. Their souls can find the necessary courage and energy to bear the burden of illness. Finding meaning in suffering eases its weight. Jesus does not promise to take the load away, but to make the carrying lighter and easier because of sharing the yoke. The rest he promises is "not of existential peace of mind, but of God's presence with a people who live according to God's revealed will and free of tyranny from imperial powers." [57]

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[56] Pregeant, 82.

[57] Warren Carter, *Matthew and the Margins: A Sociopolitical and Religious Reading* (Maryknoll, NY: Orbis Books, 2000), 259.

God's work of giving rest is underway through Jesus, God's agent.[58] The chaplain who approaches the burdened patient is God's agent, there to help find spiritual rest and inner peace. Assessing the patient's spiritual needs means ascertaining what would give this person rest and solace in their soul. It is remarkable that, in the midst of the exhaustion and efforts to cope with illness, people find great strength from knowing there is someone or something they can hold on to and trust. Psalm 23 describes the psalmist's awareness that he can hold on to God, "Even though I walk through the valley of the Shadow of death, I will fear no evil, for you are with me, your rod and your staff they comfort me."[59]

"For my yoke is easy and my burden light".

When oxen were yoked, they were usually yoked together, each sharing a piece of the burden, working as a team to accomplish the task. This clearly eases the burden on each one, making it lighter and more bearable. Patients who are open to this invitation, can experience the powerful support of community, and the assistance of their God who shoulders their yoke with them.

It helps a great deal to know that someone knows and cares about the pain. Illness can be a time of reconnection to one's inner resources and the promises of God to constantly replenish, nourish and enliven these inner strengths of trust, hope and courage.

This passage from Matthew, "Come to me..." may well be more familiar to persons of Christian faith tradition. However, it is an invitation of God for all -- to persons of different faiths and persons with no faith. God is present everywhere as the

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[58] Ibid.

[59] Psalm 23:4.

life force or energy or power that sustains life.[60] This passage seems to indicate that the same God wants people to come and receive the gift of a companion to shoulder the burden and to be available to the energy (grace) that is offered freely. It is a gift not of merit, or wages, but readily available and freely given. Meister Eckhart reminds us that "God is always present, we are the ones out for a walk." This project will offer an opportunity for those who are disconnected from their own inner spirit, to come home to themselves and discover strength, hope and comfort that awaits their attention. Then they can truly "find rest for their souls."

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[60] Michael Morwood, MSC, *Tomorrow's Catholic: Understanding God and Jesus in a New Millennium* (New London, Ct.: Twenty Third Publication, 1997), 36.

CHAPTER 9

THEOLOGIES OF LONG ISLAND

Over the five years that I have lived on Long Island, I have contemplated so many metaphors for the spiritual journey. I have been transported by the beauty of the water and regularity and faithfulness of the tides. I have watched the fishermen at my local dock and pondered on their patient wait to hook a fish, and then release it to its familiar waters. I have complained about the challenge to battle traffic to get over the bridges, yet, their expansiveness and the genius involved in their building awes me. Nothing soothes my own soul as much as a drive through the farmlands and the vineyards. My sense of God's invitation to "Come to me and I will give you rest," comes alive as I walk the beach or simply sit and attend to my surroundings. This is the home of the people I serve in ministry, and an important part of the arena where they also meet their God.

Out of my experience of living and ministering on Long Island, I developed theological theses that interweave the geographical and spiritual elements of this environment. The following pages reflect on the metaphorical significance of the bridge, and with some very obvious local theologies that are accessible to those who are at the heart of this study, patients who hear the call, "Come to me and you will find rest for your soul."

The Bridge

Long Island is an island, connected to the big city of New York and to the mainland by bridges. To get on or off the island, it is necessary to encounter one of several bridges, or one underwater tunnel. One of the most significant sociological figures of this century who had a fascination for bridges, and who wrote about them eloquently and with profound depth, was Georg Simmel.

Georg Simmel (1858-1918) was born in Berlin, Germany, and lived there most of his life. He was the founder of the German Sociological Association, and has left a lasting imprint on the international field of sociology. His interests and passion for this world and the people in it have influenced the development of theoretical orientations in social psychology, urbanism, conflict, exchange, interpersonal communication, and small groups. Simmel was fascinated by the mutual influence and interaction between our external world and our internal world, how our social, geographical and physical lives shaped our spiritual lives, and how our spirituality shaped our social and physical environments.[61] As he reflected on and wrote about "the bridge", he articulated how our physical and social environments reflect each other. Our "will to relate, is what pushes us into an empathetic mode that bridges our separateness and allows us to establish processes through which we create one society."[62] He views bridges as connectors, connecting one piece of land to another, and even more so, one group of people to another.

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[61] Victoria Lee Erickson, "On The Town With Georg Simmel: A Socio-religious Understanding Of Urban Interaction," *Cross Currents*, Spring, 2001, http://socio.ch/sim/work.htm. (accessed August 29, 2006).

[62] Michael Kaem, "Georg Simmel;s 'The Bridge and the Door'," *Qualitative Sociology* 17, no. 4 (1994): 407. Quoted in Victotia Lee Erickson, *Cross Currents*.

Bridges are massive undertakings, taking years to plan and to construct. The preparation and planning are perhaps of greater importance than the task of constructing because of the detailed attention that needs to accompany each minute plan. They must be built to withstand four types of forces or stressors that act on them: tension and compression, which both pull apart and squeeze together, the sliding force of shear and the twisting force of torque.[63] Bridges are a fascination to people in all walks of life, and artists and poets have included them in their creative expressions down through the centuries.

The Mona Lisa has a semicircular bridge in the background; Monet made the bridge at Giverny famous, as Renoir did for the Pont Neuf in Paris. Bridges are featured in the paintings of Botticelli, Raphael, Cezanne, van Gogh, to name a few. The Brooklyn Bridge, with its two great towers and its massive and magnificent steel cables, is the most painted, sketched, photographed and admired bridge in the world.[64]

Perhaps Simmel's description of bridges as uniting what is separated and creating relationships, is no less than the quest of the human heart for connection and relationship. Society happens because of the willingness of people to relate to each other. The will to connect is what creates the path to healing in any encounter, and in an intentional way, in the pastoral encounter. A recent article in the NY Times, entitled, "The Lonely American Just Got Lonelier," refers to a study by sociologists at Duke and the University of Arizona whose findings indicated that, on average, "most adults only have two people

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[63] Judith Dupre, *Bridges: A History of the World's Most Famous and Important Spans* (New York: Tess Press, 1997), 12.

[64] Ibid., 7.

they can talk to about the most important subjects in their lives.... And about one quarter have no close confident at all."[65]

This same article names other studies that suggest "that a weakening of community connections is in part responsible for increasing social isolation."[66] This latter study goes on to say that because both spouses now work in jobs that are important to them, they have more to share with each other at home. Likewise, on another positive note, important and serious personal information is shared through the internet, a bridge in cyberspace that transcends the limitations of human presence and distance. For persons who may be isolated through illness, it can be a very positive connecting and supportive medium.

Bridges make all the difference between connection and isolation. They are powerfully sturdy structures and, simultaneously, they are vulnerable to an assault of human-made and natural stressors. This demonstration project will assist persons to cross the bridge into their own inner spirit. Of course, there will be some who will choose to not cross the bridge, or some may have experienced spirit "bridge failure"[67] through neglect, wounds or assault of one kind or another. The job of the chaplain in this project is to create pathways that help persons walk into their own inner connections, to reconnect the broken and alienated parts of themselves and to find connections with

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[65] Henry Fountain, "The Lonely American Just Got a Bit Lonelier," *New York Times*, July 2,2006, 12.

[66] Ibid.

[67] Victoria Lee Erickson, *Cross Currents*.

supportive others across the span. The following poem speaks rather eloquently to this theme:

> Here we meet upon this bridge
> That reaches heaven to earth
> A visible mingling of mercy and truth
> Of kindness and human worth.
> You and I along this arc
> That spans the changing tides
> Are stirred by grace to be lanterns lit
> At one another's side.[68]

A bridge is a powerful metaphor for what this project plans to achieve. However, there are several other great metaphors for Long Island that also speak, as Georg Simmel would believe, to the interrelatedness between the social, geographical and spiritual environments of this Long Island. Georg Simmel believed that "playfulness was required of serious inquiry so that we might all be saved from what he called the *coming formlessness*, a kind of chaos that sends angels back to heaven and humans to nowhere at all."[69]

Local Theology on Long Island

Local theologies reflect the environments in which they operate, and communicate in ways that engage the minds and hearts of the listeners and readers.[70]

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[68] Catherine R. Seeley, "Here We Meet", unpublished poem that accompanies a St. Catherine of Siena bridge painting that hangs in the entrance of St. Catherine of Siena Nursing Home, Smithtown, NY. Printed with permission of the author.

[69] Victoria Lee Erickson, *On the Town with Georg Simmel* , 2.

[70] Clemens Sedmak, *Doing Local Theology: A Guide for Artisans of a new Humanity* (Maryknoll, New York: Orbis Books, 2002), vi-x.

They use images and metaphors that are familiar to the audience and they assist them in discovering the meaning and the blessing that each one potentially reveals.

Theology of Bridges and Tunnels

Bridges are used for connecting, for crossing over land or water and for returning to home. The bridge connects the island to the mainland, to its source of strength and nurture. People from Long Island commute over bridges and tunnels to get to work. They get their livelihood from the mainland and return to their place of safe harbor with the sustenance they need to live and support their families. God is our mainland. God is our source of connection to the whole. For Christians, Jesus is our connection to our creator God, our resource for nurture and strength that is beyond our imagining.

Frequently, patients, such as those who are the focus of this demonstration project, are persons who have not given time to awareness of or connection with the source of their being. They have had busy lives, going over bridges and through tunnels, paying attention to the external environment, but not having much time for the inner landscape of the soul. Going through difficult times can feel like going through a tunnel without lights, only darkness. The external environment is not as important perhaps, but now the inside also feels very dark and empty.

A chaplain, an agent of God, can walk with patients into the local milieu of their heart and stand with them as they begin to make connections with their own stories, their personal value systems, their inner selves. In the darkness and coldness of the tunnel, it may be poetry remembered that will touch them, or a childhood prayer, or help to voice their pain and anguish that will reconnect them to their deep heart's core, their mainland,

their God. Attentiveness to the inner self may connect them with strength, courage and peace they did not know possible in their illness. This, in turn, may inspire and encourage them, once discharged, to live their lives more deeply.

Theology of Harbors and Marinas

Harbors and marinas offer shelter, safety, repair, refuel, and rest. They are safe places in a storm, refuge for the vessel in distress. They offer potential as well as actualization. For the many boat owners of Long Island, marinas are familiar contexts that represent relaxation and the peaceful ebb and flow of the tides. Illness often causes a major crisis for people, not unlike an ominous storm that can turn an otherwise normal boat ride into a life-threatening adventure. The hospital may be the safe harbor where they can be sheltered, observed and treated. What the body needs for cure can be tested, poked and prodded, cut and repaired. What the soul needs is not so readily observable, though it is not infrequent that the illness of the body may point metaphorically to an aching in the soul. "Come to me all who labor and are heavily burdened, and I will give you rest..."(Mt.11: 28). God is the safe harbor for those who feel battered and worn out from the battle with illness. But, how do they know that? Who will be their messenger, their interpreter? Who will help them put words on their pleas? Who will be their anchor? "Come to me... and I will give you rest". (Mt.11: 28), and "Then they cried to the Lord in their trouble, and he delivered them from their distress; he made the storm be still, and the waves of the sea were hushed" (Ps.107: 28-29).

Theology of Tides

Tides have highs, and lows, and currents. There is very little that is static about tides. As soon as they have completed their land-bound journey, equally as soon, they begin their withdrawal to another shore. The same could be said of life as we know it: the only constant is change itself. When someone becomes ill, the rising tide of illness swells and can be quite overwhelming in its magnitude. Illness and pain can crest into engulfing waves of panic.

Just as high tides do, indeed, make all boats rise, profound questions of meaning rise to the surface in illness or crisis, questions that challenge the deepest inner core of the person. A good pastoral encounter can hear the questions, validate them, and companion the person's search for understanding. The chaplain is not there to preach or tell the person what the appropriate feelings are for the occasion, nor is the chaplain there to help the person find spirituality, or "get" spirituality. The person may not have been aware of his or her spirituality may have been too busy trying to avoid or ignore or deny that aspect of self. Whatever the case, it is a given that as human beings we are spiritual creatures.

The professional chaplain brings sensitivity to the little theologies of the context and the story of the patient. The chaplain brings a consciousness of the presence of the holy and the yearning of God to be a source of strength and comfort for this suffering human being. The chaplain is trained theologically, but it is not the professional theologian or the pastoral theologian that the patient needs. It is someone who can appropriately assess the needs and call on whatever method that could be a solace to the

patient. The method may be to journey with them into their own deep stillness that is undisturbed by the high tide.

Spiritual needs, questions of meaning and direction, "why me?", "why now?" are questions that accompany crises and life challenging illnesses, just as sure as the gravitational pull of the sun and the moon on the earth that causes the tides. The variants will reflect the person's own sense of meaning, the support system available, among other factors. My project will reflect a continuum of care for persons who have not previously paid much attention to their spiritual life and who now, through illness and hospitalization, have awakened to that aspect of themselves. "The Lord is faithful and he will strengthen you and guard you from evil"(2Thess.3:3).

Theology of Vineyards

Long Island has a great number of vineyards that provide beauty for the terrain and enjoyment for participants in the festivals and imbibers of the fruit of the vine[71]. Early in the year, however, it is also hard work to do the pruning and the laying out of the branches so they get good exposure to sunshine and rain. It takes patience and a trust that the product will be worthy of the effort. There are many little theologies and spiritual parallels we can make with the image of the vineyard, and Scripture is profuse in its references to the vine and the vineyard.[72] "I am the vine and my Father is the vine grower" (Jn.15:1) speaks poignantly to the reality of God in our lives as humans.

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[71] There are 60 vineyards, ranging from two and a half acres planted to over 500 acres. Long Island's vineyards are visited by over a half million visitors each year. (www.liwines.com)

[72] The New American Bible Concordance lists 26 references to vines and vineyards.

God is present in the work to produce the fruit, as well as being the stem from which the fruit draws its sustenance. That vine is not limited in its texture or quality. Its limits are with the choices of the human person to avail of the nurture and richness. Hospitalization offers an opportunity for persons to stop and reconnect with the meaning of their lives apart from their functions. The chaplain walks with them through the maze of their vineyard, assesses what is there, listens with the heart, helps them deal with painful debris or misappropriated values. From the "press" of the skilled chaplain "vintner", is offered a cup of kindness, that is full bodied with hints of insight and encouragement.

Theology of Farms

I grew up on a large farm in the middle of Ireland. The memories of the quiet and the stillness are etched in my heart and soul. So also are the memories of the interdependence of everything and the cooperation and collaboration that were essential for the farm to produce anything. As indicated in the introductory section on Long Island, the farmlands are diminishing by the week. The rush to sell is indicative of this cultural milieu, where the patience needed to let nature grow at its pace and trust its process, is threatened by the fast fix and the more fiscally lucrative product. Human and spiritual growth is also challenged as our fast pace limits the time for quiet and fermenting for fruitful growth. When this occurs we are not just diminished as individuals, society is diminished. "We are one body", we are interconnected one to the other. Life needs moments of quiet and stillness, and not constant frantic movement.

When the rushing is interrupted with illness, then there is the empty barren soil of the soul that may not know what to do or how to be with itself.

The trained chaplain can be with hospitalized persons in a manner that honors and trusts their spirit, in whatever season it finds itself. The chaplain is there to bear witness to the struggles and to be present to the pain. They are there to not let the "farm" be lost in the midst of the technological and scientific world of medicine. They are there to bridge the gap and to help the patient find and take responsibility for the growth that will bear fruit in its season. "Be patient, therefore, brethren, until the coming of the Lord. Behold, the farmer waits for the precious fruit of the earth, being patient over it until it receives the early and the late rain" (Jas. 4:7).

No Man is an Island[73] *by John Donne*
No man is an island, entire of itself;
Every man is a piece of the continent, a part of the main;
If a clod be washed away by the sea, Europe is the loss...
And any man's death diminishes me, because I am involved with mankind...

Center of Hope[74] *by Catherine R. Seeley*
Magnificent creation, courier of truth,
I marvel at your message.
Writ within one small foot of your rich soil,
An earthen broadcast of divine revelation.
Deep inside this rich, complex loam
Thousands of life forms thrive and mingle,
Reminding us who toil in other gardens
Of this center of hope, this good news:
All life is interrelated, interdependent.
One multitude of different potent beings
Pulse and proclaim, as prophets might,
Behold! In this haven, the design of possibility:
Unimaginable unity, unimaginable diversity!
Behold! Upon each life, God's ratifying signature:Intrinsic value, inestimable worth.

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[73] John Donne, "Meditation XVII: No Man Is An Island," *Google.MSN Search*, http://isu.indstate.edu/ilnprof/ENG451/ISLAND/ (accessed August 21, 2006).

[74] Catherine Seeley, *Center of Hope*, 2005. Unpublished poem. Printed with permission.

CHAPTER 10

COMPARABLE MINISTRIES

Prior to discussing comparable ministries that work toward awareness of spiritual issues and concerns, it is important to make some distinctions between religion and spirituality. They are often confused and they are not synonymous. Yet, as many groups as are invested in this topic, there is no common definition of spirituality. There is general consensus that spirituality is broader than religion. Religion consists of the beliefs and practices of a group that often inform a person's spirituality and spiritual practices. The term 'spirituality" is used in many ways, with St. Iranaeus' classical definition being, "a search for meaning and direction." It includes religion but is broader and inclusive of all religions and of no religions. Rachael Naomi Remen, MD, sees spirituality as "our birthright as humans."[75] For her, it is not that we have a soul but that we are a soul. Spiritual experience is not taught; "it is found, uncovered, discovered, recovered."[76]

Spirituality is that which gives meaning to life, which shapes the values around which choices are made, and which draws one to transcend oneself. Its expression can include prayer, meditation, nature, relationship with God or a higher power, creativity and aesthetic enjoyment. Illness and threats to a person's health prompt a person to ask

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[75] Rachael Naomi Remen, MD, *My Grandfather's Blessings: Stories of Strength, Refuge, and Longing* (New York: The Berkley Publishing Group, 2000), 144.

[76] Ibid., 178-9.

questions about the meaning and purpose of life. The values and assumptions about life are revisited and reevaluated when a person becomes ill or incapacitated.

Over the past twenty years there has been a growing acceptance of spirituality and the role it plays in mental health care, without diminishing the importance of psychology. Many studies have attested to the place of spirituality and religion in promoting, restoring and maintaining health.[77] There is a growing movement in medical colleges to include spirituality in the curriculum and to alert physicians-to-be that this is an integral part of the human person. Dr. Christine Puchalski at the George Washington Institute for Spirituality and Health is working tirelessly, with the assistance of grant monies from the John Templeton Foundation, to promote the inclusion of education related to spirituality and religion in medical school curricula. Heretofore, medical students were trained in the medical model which focused on the symptoms and treatment of an illness, with limited attention to the personhood of the patient. It is a positive step forward that medical education now places emphasis on seeing the whole person, attending to the spirit of the person as well as the body. The emphasis is on helping the physician to engage and address the spirituality of the person, to consider the spiritual pain and, when necessary, to refer to the subject matter expert, the certified chaplain. Daniel Sulmasy, in his book *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals*, says that if a physician is afraid of the person's spiritual pain, then he or she will neither

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[77] Conrad 1985, Moberg 1982, Byrne 1979, Larson 1991, Poloma 1991, Ozman, Freeman & Menheimer 1995, Simonton, Mathews & Creighton 1978, Sullivan 1993, to name a few of the studies on spirituality and health.

notice it nor hear it if the patient tries to speak it. The physician will apply band aids, but never truly heal.[78]

The Center for Spirituality, Theology and Health, based at Duke University Medical Center, provides opportunities for research on the relationship between religion and health and in particular, the theological and medical implications for this relationship.[79] Harold Koenig, MD, is Associate Director of this Center and writes copiously on the research findings that show strong correlation between a person's spirituality and health.[80]

The Spirituality and Health Interest Group at Medical University of South Carolina (MUSC) is a multidisciplinary group of practitioners and faculty who encourage education in spirituality and health matters. Their vision "is to see the spiritual perspective of patients and providers fully integrated into health care education and practice."[81]

This high interest in spirituality and its importance in care for the whole person, is encouraging and hopeful. On the other hand, this demonstration project is not about making a case for the inclusion of spiritual care in the care of the patient, as much as it is about helping the patient who has little interest or awareness of his or her own spiritual

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[78] Daniel Sulmasy, OFM, MD, *The healer's Calling: A Spirituality for Physicians and Other Health Care Professionals* (Mahwah, NJ: Paulist Press, 1997).

[79] http://www.dukespiritualityandhealth.org/ (accessed September 8, 2006).

[80] Harold Koenig, MD, *Spirituality in Patient Care: Why, How, When and What* (Philadelphia: Templeton Foundation Press, 2002). This book is intended for physicians and other health professionals who wish to know how to integrate spirituality into clinical practice in an effective, sensitive and sensible manner.

[81] *Spirituality And Health At Musc*, http://www.musc.edu/dfm/Spirituality/Spirituality.htm (accessed September 9, 2006).

reality. Possibly, the question from the doctor or other health professional may be what sparks the interest and curiosity in the patient. It might be the doctor who alerts the chaplain to the spiritual vacuum in the patient's life.

Religious affiliation is positively correlated with the psychological well-being of patients. For example, a study of 272 elderly out-patients showed that religious activity was significantly and positively correlated with happiness, a sense of usefulness and personal adjustment to the events of life.[82] Again, 212 peer-reviewed studies of religious commitment and health showed that 75% had positive impact; 17% had mixed or neutral impact and 7% had negative impact. The obvious conclusion is that attention to one's spiritual needs is good for overall health.[83]

Likewise, in my conversation with a discharge nurse, she reported that it is usually evident to her which patients gain strength from their spiritual heritage and which patients seem totally alone and alienated from even themselves. These latter are the patients who have more spiritual pain and loneliness and whom she will see on recurrent visits to the hospital.[84].

From an ethical point of view, spiritual care is considered a necessary part of health care precisely in its service to persons in their search for health in all levels of their being, physical, emotional and spiritual.[85] Nurses and Social Workers have contributed a

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[82] Sulmasy, *The Healer's Calling*, 57.

[83] Ibid., 58

[84] Suzanne Muccio, interview by author, September 9, 2006.

[85] Benedict Ashley, OP and Kevin D. O'Rourke, OP, *Health Care Ethics: A Theological Analysis* (St. Louis, MO: Catholic Health Association, 1977), 394-419.

lot to the understanding of spiritual issues because they observe the positive impact of spiritual connectedness on the person's coping abilities, and the corresponding difficulties experienced by patients who are disconnected or alienated from their own inner spirit. Nurses generally include a question about spiritual involvements in their admission assessment of a patient. The North American Association of Christian Social Workers (NACSW) is an interdenominational membership organization that supports the integration of faith and spirituality with professional social work. Its mission is "to equip its members to integrate Christian faith and professional social work practice."[86]. Its web page includes a Statement of Faith and Practice and a Prayer Corner, quite like what one might expect to find on a chaplain's web page.

This chapter on comparable ministries would be incomplete without mention of a physician who has opened up the field of spirituality and spiritual awareness. Herbert Benson, MD, the founding president of the Mind/Body Medical Institute (MBMI), and the author of numerous books and publications, is one of the first Western physicians to speak to the importance of spirituality and healing in medical practice. His work on the relaxation response shows helpful ways to relieve stress and improve health and well-being. His work, as described on his web page, "serves as a bridge between medicine and religion, East and West, mind and body, and belief and science."[87]

Spirituality is not limited by any ministry or any profession, primarily because any time there is human involvement, there is spirituality that is an essential part of each person. We are not embodied beings with a spirit, but spiritual beings with a body. There

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[86] http://www.nacsw.org/index.shtml. Accessed April 30, 2007.

[87] http://www.mbmi.org/benson/bio.asp Accessed April 30, 2007.

are efforts in many health facilities, particularly those that are faith based and mission driven, to develop spirituality in the workplace. The New Age Movement has also impacted a heightened awareness of spirituality and our relationship to a spiritual force in the universe that is greater than all of humankind.

In terms of this demonstration project, one positive outcome of the above comparable ministries is that the resources and opportunities to develop and grow spiritually are abundant and will be referenced in the information given to interested patients. The challenge is for the person to open up to his or her own spirituality and then seek the resources to help foster spiritual growth and enrichment.

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CHAPTER 11

IMPLEMENTATION OF THE PROJECT

This study began with a pre-survey to ask chaplains about their experiences with patients who are unaffiliated with any worship community and disconnected from their own inner spirit. This pre-survey was sent to 15 chaplains. It asked how many patients they met and what were patients' general responses to the chaplain visit.

Seven responses were returned. Of these, several said they did not meet many patients who had said they had no spirituality. However, the responders did meet many who were not affiliated with any congregation and this included those who rejected formal religion because of resentments or past negative experiences. Two of the chaplains said they meet such patients several times a week.

Five of the chaplains who responded indicated that they were not sure if a follow-up phone call would be welcome, and they also indicated that their time and schedule did not allow for such additional pastoral care. Two certified chaplains agreed to be part of the study. They were sent the package and education was done over the phone.[88]

Education:

The planned training sessions did not take place for the certified chaplains because just two persons were involved. They were oriented to the program and educated over the

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[88] See Appendix A

phone, following the educational elements outlined in the plan.[89] Copies of the study packet were sent to them and regular telephone conversations and e-mails kept the communication open. The training of the CPE students was included in their curriculum, as was weekly discussion of their on-going experience and progress. Several of them were actively involved in researching appropriate contributions to the resource booklet. However, the CPE unit ended while many of the four-week follow up telephone calls were still in process. Consequently, the weekly processing of the experiences with the CPE peer group did not occur, though the telephone follow-up pastoral visits and documentation of the calls continued to take place. Nonetheless, at this point, students were more familiar with the expectations and able to continue more independently, and the regular reporting to me took place less frequently.

As the study got underway, it did not seem necessary to involve the discharge planning nurses at this time. The students identified the patients in their pastoral rounds and did their own follow-up without needing the assistance of the discharge planners. The site team reviewed the process at each meeting and gave input about its implementation. One very helpful comment was their emphasis on being clear with the patients that it was important that they stay with the study through the four weeks.

The interviewers began their work of identifying patients towards the latter part of October (Goal 1). The emphasis was more focused on ascertaining the patient's connection with a community of worship, and less on assessing their most recent spiritual awareness. None of those identified were actively involved with any faith community. The interviewers were asked to only take two patients at the same time, so that their

[89] See Plan for Implementation, Chapter 4.

telephone follow-up would not be a liability in terms of their expected time for inpatient care visits. Consequently, the number of patients identified was smaller than the expected eighty, with forty giving their consent to be part of the study.

The next step was to provide spiritual support to the discharged patients who agreed to be part of this study, and who wished to have spiritual support through telephone calls over a four-week period (Goal II). The Spiritual Well Being Scale, discussed below, was administered on the first and fourth telephone call. This was to ascertain whether there was any change in the person's well-being score between weeks 1 and 4. These were the focus for the pastoral conversation on those particular weeks. The interviewers were given guide questions to facilitate their conversations during weeks 2 and 3 and asked to keep notes on the content. The two Spiritual Well Being Scales and all the notes were given to me at the end of each person's 4-week series.

The intent of Goal III was to link people to resources that they could access themselves in order to support their spiritual journey. During the course of the study, a list of website resources were made available to patients. As this study is ending, a more developed booklet[90] is completed and contains a wide selection of quotes from sacred texts of many faiths, inspirational quotes, prayers, poems, some books, retreat sources and website pages.

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[90] see Appendix F.

Spiritual Well Being Scale

The Spiritual Well-Being Scale[91] was selected as a benchmark for assessing the spiritual and existential well-being of patients. This scale was constructed in 1976 and has been used in over 200 studies, with a substantial number in health related settings. There are twenty items on this scale and the overall Spiritual Well-Being (SWB) is computed by tabulating the responses to all items. There are two subscales: the Religious Well-Being Scale (RWBS), an assessment of well-being in a religious sense; and the Existential Well-Being Scale (EWBS), an assessment of a person's sense of life meaning and purpose. The scale has high reliability, with total coefficients of .93, .99, and .82.[92] Research has shown that the scale is a good indicator of well-being, and is particularly sensitive to the absence of well-being. According to the authors, the indicators are correlated positively with a positive self-image, sense of meaning and purpose in life, physical health and emotional adjustment. They are negatively correlated with the opposites, i.e., health, poor self concept, lack of purpose or meaning in life and poor adjustment to the circumstances of life.

Reasons for choosing the Spiritual Well-Being Scale (SWBS)[93]

This scale was chosen for the project because of its simplicity and reliability. It would not pose an excessive burden on the patients and takes only ten minutes to

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[91] R.F. Paloutzian, & Ellison, C.W, *Manual for the Spiritual Well-Being Scale* (Nyack, NY: Life Advance, Inc, 1991).

[92] Ibid, 3.

[93] This SWBS is used with permission. See Appendix D.

complete. Each item is answered on a 6-point Likert scale, and patients are asked to agree or disagree with the statements. Ten of the statements contain the word "God", and administrators of the scale were encouraged, when appropriate, to replace this word with "Higher Power". The creators of the scale have determined from baseline studies for various samples that the SWBS is not noticeably affected by the sex and/or age of the patient. Therefore, while this particular study recorded the age of the patients, it did not indicate whether they were male or female.

The Findings of the Study

Both the first and fourth week inventory questions were done over the phone, after the patient's discharge from the hospital. The hope was that the administration of this inventory in week 1, and repeated in week 4, would show some improvement in the well-being of the patients, based on the four weeks of pastoral telephone visits to support and nurture the person's spiritual life.

Two certified Chaplain participants and four CPE interns approached patients prior to discharge from the hospital and ascertained their interest in the study. At this time they gathered some background information about the patient, asking questions about religious affiliation, and interest in this project.[94] Information about the patient's age and diagnosis were obtained from the patient chart. There was a small number of patients who were too ill or not interested in participation at this time. However, those who agreed were willing and eager to have follow-up telephone calls that would support their spiritual journey. The patients contacted were those who had a pastoral relationship

[94] See Appendix B.

with the chaplain during their hospitalization. Participants were asked to answer the questions of the SWBS during the first and fourth telephone calls. The interviewers were given guides for their conversations in the two intervening weeks.[95] They had very favorable experiences with the follow up visits, though some reported having to call repeatedly because the patient was unavailable at the time of the call.

There were eighteen patients in the study. The ages ranged from 36 to 77, with a mean of 60.5, and a standard deviation of 12.9 (Fig.1)

Statistics

AGE

N	Valid	18
	Missing	0
Mean		60.5000
Std. Deviation		12.88067
Minimum		36.00
Maximum		77.00

Fig.1

We wanted to see if there was a difference between persons who had a one-time illness and those with recurrent illness and recurrent hospitalizations (Fig.2).

ILLNESS: RECURRING OR NEW

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	RECURRING	7	38.9	38.9	38.9
	NEW	11	61.1	61.1	100.0
	Total	18	100.0	100.0	

Fig. 2

[95] see Appendix B.

Seven of the eighteen patients, 39%, had recurring or chronic illnesses. Eleven, 61%, were hospitalized for a new medical condition.

Since the goal was to make pastoral contact with persons who were currently not participating in any community of worship, we wanted to see if persons were affiliated with any religious group and non-participating, or if they were never associated with any faith community. (Fig. 3)

AFFILIATED RELIGIOUSLY ?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NO	8	44.4	44.4	44.4
	YES	10	55.6	55.6	100.0
	Total	18	100.0	100.0	

Fig. 3

There were 44% who were not ever connected with any religious affiliation, and 55% said they have not been involved since childhood.

The goal was also to help these persons connect with some source of spiritual nurture. We asked if they were interested in assistance to initiate contact with their religious congregation. Four of the eighteen wished such contact and fourteen indicated that they either did not wish any connection at this time, or they would initiate it themselves when they were ready.

The above pre-survey questions were completed prior to the patient's discharge from the hospital at the time they were told about the study and agreed to participate in it.

Findings of the Spiritual Well-Being Scale (SWBS)

The chaplains completed the first round of the SWBS during the first telephone call one week after the patient's discharge to home. The last week of the follow-up calls, this same scale was repeated. The following are the findings:

	Total Sp. WellBng		***Total Rel. WellBng***		*Total Exist WellBng*	
	Wk1	Wk 4	Wk1	Wk 4	Wk 1	Wk 4
Mean	83	82	42.	43	41	39
Minimum	62	61	29	26	33	27
Maximum	106	109	57	60	52	56

Fig.4 – Comparisons of weeks 1 and 4 in each area of well being.

The above numbers display the mean scores of the three Spiritual Well Being measures – Total, Religious, Existential – at Week 1 and at Week 4. As seen in this table, the Week 1 means do not look substantially different from the Week 4 Means for each measure. Beginning with the Total Religious Spiritual Well-Being measure, its Mean at Week 1 was 83 and at week 4, it was 82. The difference between the two Means, i.e., -0.89 is not statistically significant. There was no significant change in the overall well-being of the patients over the four weeks of the telephone follow up pastoral conversations.

This was a particular group of patients who were not connected to a community of worship. Nonetheless, it does appear from the study, that they had significant levels of spiritual well being, with very little differences noted in week 4. According to the

authors of the scale the following measures are indicative of a person's overall spiritual well being:

*Range 20-40 mean low spiritual well being;
*41-99 indicate moderate spiritual well-being, and
*100-129 indicates high spiritual well being.

Further study of the Figure 4 show that while none of the 18 patients in the study rated with low spiritual well-being; 15 out of 18 rated with moderate spiritual well-being; and three rated with a high level of spiritual well-being in the first week,[96] with quite slight differences in the fourth week. Likewise, in the area of religious well-being, which measures a person's relationship with God or a Higher Power,

*Range 10-20 means basically an unsatisfactory relationship with the divine;
*21-49 indicates a moderate religious well-being; and
*50-60 indicates a very positive view of a person's relationship with God.

No one rated with an unsatisfactory relationship with God; 16 out of 18 respondents rated with a moderate religious well-being; two respondents rated with a very positive view of their relationship with God and again, with only slight variations between weeks I and 4.

The pattern in the Existential Well Being , where the focus is on life satisfaction and life purpose, is consistent. The authors of the scale offer the same numbers as for the religious well-being. Similarly, fifteen patients indicated a moderate level of life satisfaction and purpose, and three showed a high level of satisfaction with life and a clear purpose.

These figures remained relatively similar when the same SWBS questions were

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[96] See Appendix E for comparison charts of the 18 individuals in the study.

asked at the end of four weeks. However, in the fourth week, it is curious to note how some of the differences showed up with a slightly smaller number, rather than a positive. I feel confident that patients were not hurt or spiritually diminished, and can only conclude at this time that there were not enough weeks in the interim to adequately and accurately assess any improvements in spiritual well-being. Clearly, there were individuals who benefited from the follow-up, but the group as a whole was not changed. In the aggregate, there is no evidence of improved spiritual well being according to this scale.

Despite the above quantitative figures, there are considerable qualitative references that are significant. These were included in the discussions in the intervening weeks and in the last week. They were also gathered from a meeting with those who were involved in administering the SWBS and follow-up telephone calls with the patients. The following are qualitative comments of patients and reported by the interviewers:

♦Three patients requested that the telephone conversations continue, at least monthly, because it meant so much to them that someone would call and have time and interest enough to listen to them.

♦An elderly woman whose husband of many years had died three months prior, said, "I have no one to listen to me and my worries. You did that and I am grateful."

♦A gentleman who had a recent diagnosis of cancer told the chaplain, "You helped me find a channel to relate to God. I was afraid. I still am, but now I feel God will be with me."

♦"I used to feel God was with me, but I lost that through my addictions. Now I feel I can

reclaim a part of myself and that feel good." This was said by a patient who underwent an amputation because of diabetic related problems.

♦"I feel physically sick, but not spiritually. Talking with someone is what most helps me."

♦A patient who had expressed difficulties with the religious institutions and who was initially not interested in participating in the study, said at the end of the four weeks,

♦"You were so helpful to talk to and you did not judge or preach."

♦A grandmother who was having multiple problems with health and with her life said, "I can be strong for someone else, but not for myself. You help me feel strength within."

♦"I used to think God had forsaken me, but now I don't feel that way. I feel like I am a different person." This patient feels she is now bubbling spiritually at the end of four weeks of telephone calls. She did not want the calls to end because "so much is happening to me spiritually." She signed up for RCIA and was disappointed that she has to wait so long for the next program.

♦A patient who was undergoing tests and worried about the outcomes, said, "I cry a lot. It's so scary to not know what is happening."

Other comments by patients:

♦"It is comforting to know that someone really cares about me, even a stranger."

♦"I feel that my experience is valued and validated."

♦"I am so glad you called. I thought you would not follow up."

♦"I feel I am coping a little better. Your calls really helped me."

♦"It's helpful to talk to someone who understands."

♦ "I'm overwhelmed and exhausted. I feel better after our chats. Thanks for listening."

The following comments were made by the interviewers about their experience of the telephone conversations with patients:

♦ "Patients reported that they had a good sense of being cared for."

♦ "They felt listened to and validated in their experience."

♦ "Patient felt he abandoned God, but God did not abandon him. This was a mature level of spiritual awareness. It surprised me and I felt very happy."

♦ "More time was needed for continued ministry to the patients. Four weeks was insufficient."

♦ "The resource list was very helpful, especially the web addresses for those who were still homebound."

♦ "One patient reported she was Catholic in name only, and that this illness precipitated taking a look at her life and asking where God was for her. She appreciated the calls and enjoyed the conversation."

♦ "One patient spoke of her sadness and fear over her limitations, and she felt lighter and relieved that she was heard and not judged."

♦ "Patients were happy to have resources that would help them."

♦ "One patient welcomed the telephone calls but did not want anyone from her church to visit her. She really wanted someone to clean her house."

These telephone calls often included a spontaneous prayer that spoke to God about the actual struggle of the patient. This was offered either at the request of the patient, or with the agreement of the patient. The comments of the patients and the interviewers testify to the genuine merit of the follow-up telephone calls. I feel very

confident that more happened than could be measured in the scale that was used and that patients were truly helped spiritually. The words above show that it is a mutually spiritually enriching endeavor.

CHAPTER 12

EVALUATION PROCESS

There was no difficulty in identifying patients within the hospital who were unaffiliated with any organized religion. Many claimed affiliation, but had not participated in any way for several years. A challenge of meeting the objective target of 80 patients was unreal, due to the small number of interviewers for this project. Initially, I had anticipated that many certified chaplains would participate, but just two certified chaplains were available at this time. In addition, of the seven CPE students, four were Roman Catholic priests from Africa. The challenge was two-fold: a) patients who were alienated or disconnected often had no interest in speaking with a priest, and refused to engage; b) their African accent can be difficult to understand over the phone. I therefore, let them make their choice about participating or not. One of them did make phone calls to four patients, but all of his information had to be omitted from the study, because of reasons stated above.

I contacted the hospitals and checked in with their Institutional Review Boards (IRB's) prior to initiating the study. This caused some delay in getting started. The outcome was that I did not need to go through the IRB because of the non-invasive nature of the study and the fact that the patients agreed to have a telephone call come to their homes. All the patients interviewed agreed to be part of the study and all seemed to appreciate the human contact and spiritual support.

Regarding patients linking with some spiritual resource within their community, 17% chose to do so and have Eucharistic Ministers come to their homes. The remaining

83% indicated that either a) they were not yet interested, or b) they would do so when they were ready. However, all were welcoming of the resource booklet. This booklet[97] was a variation on the original plan to develop a database for referrals. When I began to work on this, the list was so long, the dates so fluid, and there needed to be some better way of not reinventing work and resources that were already accessible. The outcome was a booklet that listed web pages for spiritual resource, some quotes from multi faith sacred texts, and quotes and poems that were uplifting and enlivening. This booklet was given to each of the participants with a thank you for their participation. It will be reviewed, added to, put on the web page for Catholic Health Services of Long Island, and possibly made available in the lobbies and family rooms of the hospitals.

In terms of evaluating the project, my leading question was: Did patients make the bridge with the Sacred in their lives through this process? The SWBS showed that quantitatively, patients who were interviewed already had a good connection with their spirituality, and did not make significant progress. However, the qualitative evidence shows that these follow-up conversations were meaningful, supportive and helpful for the patients. The call from the God who longs to strengthen them in their struggles with health and life, "Come to me and I will give you rest," was heard in the patient's willingness to participate in the study. These calls and the interventions of the chaplains were friendly reminders of the presence and care of God, whether this was expressly articulated or not.

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[97] see Appendix F

CHAPTER 13

TRANSFORMATION: OPPORTUNITIES FOR IMPROVEMENT

There were surprises, valuable lessons and opportunities for improvement in my experience of the project. As indicated in Chapter 2 of this study, the number of those who do not subscribe to any religious identification has grown from 14.3 million in 1990, to 29.4 million in 2001. For many years of my professional life, I have worried about people who no longer find a spiritual home within any form of believing community. Where do they turn for answers to the difficult questions of meaning and direction? We meet them in the hospital beds when they are stopped short by an illness and have time to ponder and face themselves as they are apart from what they do in life.

As I look at the sampling of patients who were interviewed and followed by telephone for four weeks, 55% reported no affiliation. However, their well being score was not as depleted as I would have assumed previously. It was a pleasant surprise to find that they were not even low on the scale. Most of the 18 patients were still home recuperating from their medical intervention during the four weeks of their follow up calls. Of the 38% who had recurring illnesses, it is likely that they revisit familiar questions and inner struggle. The 61% who were in for a new medical condition may be asking these questions with new urgency. The hospitalization presented a sentinel event that caught their attention regarding the place of spirituality in their lives and importance of working through the questions and concerns.

I was once again impressed with the important place pastoral care of the sick plays in this arena of illness. I am more convinced than ever that the question of denominational affiliation is far less important than the care of the soul of each patient in the bed. We need to be more alert to patients who are not participants in any faith congregation and who do not ask for a chaplain's visit. Perhaps we are there precisely for them, and perhaps God is longing and waiting for someone to assist them to open the door to their own inner self and to a source of strength and energy that is greater than themselves.

This project has provided me with some refined ministerial insights and with lessons for improving a more longitudinal and, thus, informative study.

1. The plan for this study was to identify patients who were alienated from their own inner selves and their relationships with God. The patients chosen by this group of interviewers were predominantly patients who were not participating in any faith community. The results of the SWBS showed that they were all not alienated from God. This, of course, is consistent with the findings that 66% of people in the USA have no doubt that God exists, with 14% believing in a Higher Power or cosmic Energy. The expression, "There are no atheists in foxholes" may also apply to patients whose identity and life may be threatened by an illness. Illness awakens them to questions of their own mortality, as well as the meaning and purpose of life. I learned that there are many variations of belief in God and that assessing the patient's spiritual "temperature" is the best process for care of the individual patient's particular spiritual pain.

2. This insight referred me to my ministerial competency goal to grow in awareness of my own cultural biases.[98] Though this was not "on the list" of hidden biases I was open to discovering, it is surprising to me that bias of a different kind may have been cloaked in my psyche: spiritual elitism. The fact that I was "pleasantly surprised" that this population was not on a lower scale is revealing in itself. On pages 12-13 I cited, "It cannot be assumed that if someone is affiliated with a religious institution or place of worship, that they actually participate on any regular basis. Nor can it be assumed that if someone says he/she is non-religious, that this means there is no spiritual awareness." It looks to me now that my "pleasantly surprised" possibly could be the equivalent of such an assumption. This is an awareness I will certainly reinforce with each inclusion of it with CPE students.

3. Moving from the hidden bias of spiritual elitism to cultural bias, I return to the chaplain student interviewers who were from Tanzania and Nigeria. I constantly worked on my understanding of their accents and came to wonder how these might impact follow-up phone calls to patients. I have questioned whether this is authentic "cultural bias" on my part or not, since these students' self perception was that there would be no problem with the telephone calls. I, too, am multilingual and, yet, I frequently found myself straining to understand their particular accents. Was I being too quick to make the claim of cultural bias in this instance, or was I simply a principal investigator listening with an assessing ear to whether or not there might be any linguistic impediments to the collection of data. Here is why I wonder about that: In a hospital where I once worked, a

[98] See Chapter 5.

survey of over one hundred questions was given to all staff by a national research agency. It was found that the survey had to be re-written according to a sixth grade reading level in order to be a valid instrument for all to participate. Once rewritten, the employees at all reading levels were able to complete the survey on their own. The Matthew Project differs from that survey since questions were asked by a chaplain interviewer, rather than administered to patients through a self test. However, these surveys may be similar if there is an impediment to the comprehension of those being interviewed. In the case of an interviewer orally asking the questions in the survey, as in The Matthew Project, he or she is, in essence, part of the instrument and must be easily understood. This calls for equal sensitivity to the interviewers and to interviewees. The implications for this dilemma reach far beyond this one project on Long Island and into research methods themselves as we become ever more culturally diverse as a nation.

4. The Matthew Project needs to be expanded from this "pilot" project to maximize its potential. Within the narrow time allotment for this project, one group of participants was clearly identified as in above numbers 1 and 2. However, on page 13 of this project, I stipulated that I wanted to target "persons whose worldview does not include inner self awareness, and whose basic assumptions and images do not involve any source of strength or energy beyond the purely external and physical realm." These are persons with a *non-religious* worldview that does not include any supernatural understanding. While we did encounter others with a *religious* worldview that embraced belief in a supernatural being involved with humanity, our sample simply cast too small a net to catch a representational number of persons with a non-religious world view.

5. Now about that "net." From the very beginning, the Matthew Project Site Team urged me to broaden the range and number of patients to be interviewed by expanding the number of chaplain interviewers beyond the number of CPE students. I heartily agreed and immediately complied. Of the 15 chaplains I had hoped would join in this research project, 2 volunteered and completed the project. Chaplains who declined participation in this project cited already being too overwhelmed with work to take on one more thing. This has led me to a few conclusions, along with a measure of disappointment. Time dedicated to research about the patients we serve easily can lie within the purview of the pastoral visit and will, ultimately, inform future visits. Directors of chaplaincy departments must use their leadership role to lead chaplains in an ever evolving ministry to an ever evolving demographic. My role in system wide leadership of those departmental leaders is to further, better educate them about the importance of research to their work, particularly in this locale where research in pastoral care has never taken place. As with other clinical departments involved in patient care teams, chaplains must learn to embrace research opportunities. Casual or optional interest in *how* or *why* we do what we do is as deadening as casual or optional interest about *to whom* we minister. This project has transformed some notions about my role and has given me a clearly defined direction for my own leadership in this regard and will so serve as the "next step" necessary in the refinement portion of this project.

6. A booklet, *Spiritual Resources for Difficult Times*[99] was developed for The Matthew Project. Preparing it was, in itself, transformational. The cry of the heart, in all cultures, is one. The "groaning of the spirit," in any language, can be recognized in all languages. I am excited that, because of this project, we now will be able to offer patients their own portable "bridge" by which they may cross the chasm of illness induced anxieties to the more tranquil terrain of inner strength and peace. While it may inspire, it is my hope that it also will subtly educate and transform the reader about those things inherently common to being human.

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[99] See Appendix F.

CHAPTER 14

BRIDGING THE SELF AND THE SACRED

On any given parkway or expressway, or on any bridge or tunnel connecting Long Island to the mainland, there will always be those inevitable signs, "Under Construction," which evoke visceral responses in motorists. But people get there. Patience, persistence, or even an alternative route gets them to where they were headed. In most cases, all is not lost because something just might be gained by sitting awhile in traffic. While the results of The Matthew Project indicate that this pilot project will soon be "under construction," some mileposts have been noted.

Chaplains continue to find that there are persons who find spiritual nurture outside of organized religion and who grow spiritually despite their non-participation in formal denominational worship or community. This raises questions about how our churches and places of worship meet the needs of such folk. What might be done differently so that these persons would want to be involved? While, obviously, people do not have to present themselves in a church, when they are seriously ill, they usually have to come to the hospital. How can we maximize this opportunity to address and, perhaps, help heal the "drooping spirit" as conscientiously as is addressed the ailing body? Pastoral care puts chaplains at this critical juncture for people.

In a Theology of Bridges and Tunnels, chaplains can be the arc that joins spirit with body and with mind. Because of that, I am again compelled to make sure the

pastoral visits, for which I train students, are focused and intentional in their attentiveness to the spiritual issues of the patient and family members.

In a Theology of Harbors and Marinas, chaplains can be the reassuring beacon on the choppy sea of change, signaling to those adrift or in darkness a way back to the safe harbor of God's faithfulness. It takes a keen eye and a sharp ear to pull safely into port in adverse weather. Updated charts must make up for what eye and ear lack. Research, as a navigational tool for chaplains, must be constant; it is the most reliable compass.
In a Theology of Tides, chaplains can be the shore at the low tide of one's disinterest in his or her inner life simply by being there receiving whatever washes up; or, at high tide can be the anchor that helps reduce struggle and gives rest.

The Matthew Project: Bridging The Self and the Sacred, ultimately, is an invitation to Long Islanders, through theologies of bridges, tunnels, harbors, marinas and tides, to "Come to me all who labor and are heavy laden and I will give you rest."

AFTERWORD

As a conclusion to this phase of the project, I offer some additional commentary in three areas: the impact of this study on the CPE students interviewers; comments on the 17% of patients in this study who were willing and ready to engage and invest in their spiritual growth; and implications for houses of worship that 83% chose not to reconnect with a faith community at this time.

Student Interviewers

The students who participated in the study were, as indicated previously, invested, committed and eager in their pursuit of telephone follow up calls to discharged patients who were not connected to any faith community. They knew they had done good work with the patients based on the qualitative results discussed in Chapter 11. Their goal was to keep the spiritual conversation going to a point where the discharged patient took active responsibility in pursuing his or her own spiritual journey. However, in their conversations, they were invitational rather than demanding, not forcing entry but opening doors and leaving the patient with a sense of his or her own dignity and autonomy. When the students heard the results of their work articulated in my presentation to them of the project's findings, they found it profoundly rewarding. I wish that the pleasure on their faces could be transmitted onto this page. They felt affirmed in their ministry, even though the results were not quantitatively remarkable or the patient's intended "reconnections" observable. Three of the students had continued telephone calls

with one patient each, and these conversations were shared with some sense that it was right to continue (though on a monthly basis, rather than a weekly call,) and that the patients were journeying at their own pace.

Patient Interviewees

Of patients who did reconnect with their faith community, one was a Jewish woman who had relocated her home several years ago and had not sought out her local synagogue. The visit with the chaplain reawakened in her the sense of peace and nurture she felt from her congregational participation and provided the impetus to actively reengage herself. A second lady was never initiated into any faith group, though her family was traditionally Roman Catholic. She felt supported, encouraged and hopeful through the conversations with the chaplain, and was astounded by the depth of spiritual awakening and hunger that flooded her. She signed up for the "Rite of Christian Initiation of Adults," expressing disappointment that she had to wait for several months the beginning of the next program. The third person was grateful for the assistance in connecting with a pastoral visitor from her church for sacramental care. It seems clear that these persons were ready to do more to develop their spiritual selves. Their illness made them more in tune with their spiritual hunger and their desire for nurture.

Implications from The Matthew Project for Worship Communities

The question of the impact of this study on houses of worship is significantly more complex, since shrinking congregations are a source of perplexity and angst for so many denominations. The variables are many and may also be related to the level of personal

awareness and aliveness in a person's spiritual life. Perhaps consideration of some of the following points will move forward the development of antidotes to this demise:

1. It may be that organized religion has been more concerned with education of its membership regarding dogma, rules, and prescriptives, which essentially, by adherence, create "loyal" followers. Thus, religion's "organizing" components have been overemphasized at the expense of spirituality. In other words, "the *spirit* of the law" has been given shorter shrift than "the law." The divine within has been muted, if not dulled, by overemphasis on authority from without. Attention to the divine within, spirituality, is the energy that sets in motion the action of the faith held. Perhaps this disconnect or imbalance has unconsciously failed to check the prurient promotion of materialism, obscene wealth, and power over others as the measures of personal self-worth. Maybe religions themselves are not as spiritual as they need to be.
2. Communities of worship need to meet people where they are and facilitate their further growth through engagement and collaboration. This is the practice of local theology. While most religions have governing bodies, synods, hierarchies, or headquarters, local theologies should not wither in the shadow of any ecclesial giant. Imagination and creativity are matters of the spirit. The development of local theologies should be encouraged (not held suspect) since their very referent is where congregants live. Religion must inspire people where they live.
3. Communities of worship need to preach more by their example than their words, or at least the words need to be in harmony with the observed behaviors. They

need to live, be experienced, and observed as transformational, moving the people and the planet toward the good.

4. People who are not in the pews need outreach to them, particularly in times of crises and trauma. This necessitates intentional partnering between hospital chaplains and faith communities and their pastoral ministers and/or clergy.
5. Change is inevitable in this world. Communities of worship need to model the biological, ecological, and geological realities of change. No element in life escapes change. Life is dynamic, not static. Communities of worship that are static die off because members fall away. Communities of worship need to model change, bringing communities with them, helping them understand this fundamental aspect of being alive.
6. Religious bodies need to have bold moral voices calling for the dignity and respect of every human being. They need to be self reflective and critically examine issues regarding race, gender, sexual orientation, socioeconomic class and oppressive practices within their own institutions. Honest appraisals must be made, lest they perpetuate the very practices they should be denouncing in society.

The Matthew Project was founded on this invitation:

> Come to me all who labor and are heavy laden, and I will give you rest. Take my yoke upon you, and learn from me, for I am gentle and lowly in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light.[100]

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[100] Matt. 11:28-30

These words constitute the timeless call to the institutional body of believers, every bit as much as they remain the timeless invitation to the individual bodies of hospitalized patients. Both are in need of mending. Reconnecting with and attending to the great gift of spirituality may offer even more: healing.

APPENDIX A

PRE-SURVEY MEMO & QUESTIONNAIRE SENT TO CHAPLAINS

Dear Chaplain Colleagues,

I am doing a Doctor of Ministry project on persons who are not connected to a faith community, seeking ways to reconnect them to their own inner spirit. These are the persons who say, "I have no spirituality"; "I'm not religious"; "I don't go to church", etc.

They could be persons who have not gone to church in years and now want to/need to call on God in their illness. They also could be persons who have just had no time for God or their own spiritual selves because of busy life style and lack of interest.

Can you take five minutes to give me feedback on some questions out of your own experience as chaplain? I am not looking for exact numbers, but rather your best approximation out of your own experience. I am sending this via e-mail to as many chaplains as I can reach in Nassau and Suffolk counties of Long Island. Please share it with any colleagues that you think might also be interested in responding. There is a question at the end that asks you if you are willing to participate in the study that will take place September – December 2006.

There are two attachments:

1. the questions for you to answer, and return to me ASAP and no later than September 5, and
2. the proposed study summary, plus the goals, objectives and strategies. (This is for your information.)

(SCROLL DOWN FOR QUESTIONS and for Proposed study summary)

PRESURVEY OF PROJECT

Name _____ e-mail_____

Name of Health Institution _____

1. Do you encounter patients who say they have no spirituality? Yes ____No _____

2. Do you experience such patients wanting to connect with their inner spirit?

Yes _____ No _____ % of yes_____

3. On average, how many such patients do you meet?

Each week _____

Each month _____

4. Do you feel frustrated that there is not more time to "work" with them?

Yes _____ No _____

5. Do you feel that a weekly follow up phone call for four weeks after discharge would help kindle this relationship with their inner spirit? Yes _____ No _____

6. Are you willing to participate in this research with discharged patients who consent to follow-up phone calls? Yes _____ No _____

Please see attached the challenge of this research, as well as the goals, objectives and strategies. Please e-mail back this form to marytoneill@optonline.net, and add any comments you wish. When you receive this, open it up as document, fill it in, save and send it back as an attachment. Thank you very much.

7. If yes, would you be available for a 90 minute training session on Friday, September 15th 10:00 a.m. in Melville, or Thursday, September 21, 3:00p.m. in Melville.

Yes _____ No _____

I am willing to participate, but cannot be available for the meeting. I would prefer conference call training. Yes_____ No ____

APPENDIX B

RESEARCH PACKET

QUESTIONS TO BE ASKED OF PATIENTS UPON DISCHARGE

Patient initials_____ age ___ marital status m__ s__ div_ wid__

Reason for this hospitalization (illness/diagnosis)_____

Is this illness recurring __ or new __

Length of stay in hospital? _____

Where do you find your primary support?

Family___ Spouse/Sig. Other ___ Friend___ Prof. support___ Clergy ___

Any religious affiliation Yes___ No___

Do you attend religious services? Yes___ No___

If yes how often? Once a week___ More than once a week___ Daily___

Were you visited by a chaplain? Yes___ No___

If no was this your choice? Yes___ No___

If yes was it helpful ? Yes___ No___

If yes could you briefly describe in what way?

_____

_____

Is there anything you wanted or were expecting from the chaplain that you didn't get? Yes___ No___

If yes could you briefly describe what that was?

_____

_____

If person is religious but not connected to a worshipping community:

How is your faith helpful to you? _____

_____

How do you find God in your daily life?_____

_____

What kind of spiritual support would be helpful to you when you go home?

_____

Do you want me to contact someone from your faith community and ask them to reach out to you at home?
Yes" ___ No__

If yes name of church/synagogue/mosque _____

If person is not religious:

What helps you calm anxieties?

_____

What is your source of strength?

_____

What is most important in your life at this time?

_____

Do you want a phone call to support you spiritually after you leave the hospital? Yes___ No___

Phone number where patient can be reached _____

SPIRITUAL WELL-BEING INVENTORY - FOR USE ON FIRST AND FOURTH PHONE CALL

Ask about or thank for Willingness to participate –
Ask short list of questions – not difficult –
Your answer is the right one –
Will ask you same questions on 4th week
Do you agree or disagree:

- **Agree**
  - strongly
  - moderately

Disagree:
strongly
moderately

Initials of patient ____ .
Date of call 1 _____ _
Date of last call _____ _
Name of chaplain ___ _____

1.	I don't find much satisfaction in private prayer with God.	**SA**	**MA**	**A**	**D**	**MD**	**S**
2.	I don't know who I am, where I came from, or where I'm going.	**SA**	**MA**	**A**	**D**	**MD**	**S**
3.	I believe that God loves me and cares about me.	**SA**	**MA**	**A**	**D**	**MD**	**S**
4.	I feel that life is a positive experience	**SA**	**MA**	**A**	**D**	**MD**	**S**
5.	I believe that God is impersonal and not interested.	**SA**	**MA**	**A**	**D**	**MD**	**S**
6.	I feel unsettled about my future.	**SA**	**MA**	**A**	**D**	**MD**	**S**
7.	I have a personally meaningful relationship with God.	**SA**	**MA**	**A**	**D**	**MD**	**S**
8.	I feel very fulfilled and satisfied with life.	**SA**	**MA**	**A**	**D**	**MD**	**S**
9.	I don't get much personal strength and support from God.	**SA**	**MA**	**A**	**D**	**MD**	**S**
10.	I feel a sense of well-being about the direction my life is headed in.	**SA**	**MA**	**A**	**D**	**MD**	**S**
11.	I believe that God is concerned about my problems.	**SA**	**MA**	**A**	**D**	**MD**	**S**
12.	I don't enjoy much about life	**SA**	**MA**	**A**	**D**	**MD**	**S**
13.	I don't have a personally satisfying relationship with God	**SA**	**MA**	**A**	**D**	**MD**	**S**
14.	I feel good about my future.	**SA**	**MA**	**A**	**D**	**MD**	**S**
15.	My relationship with God helps me not to feel lonely.	**SA**	**MA**	**A**	**D**	**MD**	**S**
16.	I feel that life is full of conflict and unhappiness.	**SA**	**MA**	**A**	**D**	**MD**	**S**
17.	I feel most fulfilled when I'm in close communion with God.	**SA**	**MA**	**A**	**D**	**MD**	**S**
18.	Life doesn't have much meaning.	**SA**	**MA**	**A**	**D**	**MD**	**S**
19.	My relation with God contributes to my sense of well-being.	**SA**	**MA**	**A**	**D**	**MD**	**S**
20.	I believe there is some real purpose for my life.	**SA**	**MA**	**A**	**D**	**MD**	**S**

QUESTIONS FOR WEEKS 2 AND 3

(No need to be rigid about these – meant as conversation starters and helps to tap into what patient is experiencing.)
KEEP NOTES ON CONVERSATION AS IT HAPPENS.

1. What has your week been like
2. Did you have any thoughts following the questions last week?
3. How do you feel you are coping?
4. Is there anything troubling you?
5. What was helpful to you this week?
6. Do you need suggestions for what might help you spiritually?

QUESTIONS FOR WEEK 4

This is our last follow up call. Do you feel it has helped you spiritually?

Can I ask you the same list of questions I asked you on the first telephone call four weeks ago?

((PRINT OUT SPIRITUAL WELL-BEING INVENTORY AND CHECK ANSWERS AGAIN)

Is there any way I can be of further assistance to you
-by giving you a list of spiritual resources?

-by calling your congregation/church/synagogue?

What would be most supportive of you or helpful to you as you continue to get well?

APPENDIX C

SITE TEAM MEMBERS AND MEETING MINUTES

Msgr. Dennis Regan, Pastor, St. Rosalie's Parish, Hampton Bays, NY

Very interested and supportive of project, will not be at meetings, but will be involved by telephone.

Mrs. Dorothy Horstman, Founder of "At Home Retreats" and strong experience and reputation in spirituality and spiritual direction. Very resourceful and knowledgeable regarding community resources.

Deacon Joe Scollan, chaplain, St. Charles Hospital, Port Jefferson, NY
Specific site to be used for project.

Mrs Cathy Grandjean, Director of Chaplaincy, Diocese of Rockville Centre
Works with chaplains and knows parish operations.

Msgr. Emmet Fagan, retired Episcopal vicar for Long Island. Knowledgeable about parish life and access to pastors

Caterina Mako, former CPE student and Director of Pastoral Visitation, HIP
Experience with research

Catherine Seeley, Professor of Theology and Ethics at St. Joseph College and Molloy College. Experienced with CPE process and frequent presenter for students.

SITE TEAM MEETING MINUTES

March 28, 2006

Meeting at Mary T's home, 6:30-9:30pm; dinner was served.

Agenda:

1 Description of the Program

2 Discussion of the responsibilities of the site team

3 Description of Project

4 Discussion of Challenge Statement

5 Completion of the Candidate Competency Assessment

6 Possibility of setting future dates

Minutes:

Those present were eager to hear about the program and what their responsibilities were. They were enthusiastic about the project and eager to offer suggestions and assistance in whatever way they could. They did not have any difficulties about their responsibilities.

Discussion of Project and Challenge Statement:

There was a lively discussion about the overall project.

Some of the ideas and questions included resources for demographic information Relative to

a. research and documentation of church attendance drop off and implications;

b. research on spirituality and well being

c. resources available to patients once discharged (Creighton University web site on prayer, etc)

There was a suggestion about getting access to any statistics available at the Pastoral Formation Institute, and also at the Long Island Catholic's healthcare issue and database.

The site team felt there would be a broader range of patients if the project was extended to all the CPE students in the various facilities, and also to some chaplains who may be interested in contributing. This would give us more data because of the possibility of a greater number of patients. It would also involve education of all those involved in the project.

Education will be included in the curriculum for the students. Other chaplains involved will either be invited to those sessions or have an additional evening training and orientation for them.

Next Meeting : May 25, 2006 –

This meeting was cancelled.

SITE TEAM MEETING MINUTES

September 11, 2006

The second meeting of the site team took place on September 11, 5:00pm to 8:00pm. Three of the members could not be present, but were in conversation by telephone with the candidate.

The candidate reviewed the progress on the Demonstration Project Proposal and discussion focused on five areas of challenge and concern:

1. The poor response rate from chaplains regarding the pre-survey questions. These were e-mailed to close to 15 chaplains and yielded only one response in writing. When they were resent, there were two additional responses. The site team present suggested reworking the questions to make them clearer, and then sending them out by mail, with an enclosed stamped and addressed envelope.

2. The competency assessment goals and objectives were discussed. The site team agreed that each of these could be a project in and of itself. They found the goals broad and demanding, while at the same time exciting and enlivening. Dot Hortsman did her MA paper on Fowler's stages of growth and agreed to forward a copy to the candidate.[101]

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[101] Subsequent to this meeting, the NYTS mentor did not approve of this direction for the competency goals, and so they were changed.

3. There is still a need to structure the 4-week follow-up questions for the discharged patients. These need to be formulated in a manner that will make the evaluation and synthesis of the findings more manageable. Some concerns regarding the quantity of calls were discussed.

4. The Institutional Review Boards (IRB) in each facility are being contacted for permission to do this study involving their discharged patients. No major problem is anticipated here.

5. The database is just begun and has a long way to go. CPE students are actively researching resources on a weekly basis. Local papers and libraries are good venues for information on spiritual resources.

The team then discussed the resistance among chaplains, in general, around research projects. This demonstration project is a positive opportunity to instill in the CPE student chaplains an enthusiasm and commitment to research in pastoral care.

One of the implementation plans for this project is to have the site team meet on a monthly basis to monitor and evaluate the process. Before this meeting ended, dates were set for the following months:

October 16 (or 23, if IRB's delay the start of the research),

November 13, and

December 11.

SITE TEAM AGENDA

OCTOBER 16, 2006

1. Review Minutes from last meeting
2. p. 11: Projected Goals and Evaluation Criteria
3. p. 16: Methodology – see attached page with expansion on Boisen and Lonergan – application to CPE process.
4. p. 19 – Educational Curriculum and Evaluation Process
5. p. 22 – Competency Goals and Evaluation
6. Pre-Survey results: not included
7. Questionnaire for patients – in original packet
8. Four Week follow-up – sequence – not included
9. Data Base – not included

SITE TEAM MINUTES - OCTOBER 23, 2006 – DMin Demonstration Project

Present: Dorothy Hortsman, Cathy Grandjean, Cathe Seeley, Mary T. O'Neill

1. Minutes from last meeting were approved.
2. The Projected goals and evaluation criteria were discussed.
3. Mary T. described the input received from NYTS about the need to further develop the connection between Boisen and Lonergan and how their methodologies are integrated in the CPE program.

The site team was pleased to assume responsibilities in the on-going evaluation of the project. This will be on the agenda for each meeting.

5. Mary T. described the change in focus on the competency goals and evaluation. The previous goals were removed based on the feedback from the Program mentor, and replaced with manageable and measurable goals from the Competency Assessment and Evaluation format that was worked on at the first meeting of the site team. The site team felt some relief with the new goals as presented.

6. The Pre-survey results were distributed to the site team. They did not convey any significant data. There was some discussion about the resistance on the part of chaplains to respond to this project. The results were insignificant and did not contribute to the goals of the project, nor did they describe any significant need for such a project. In general, seasoned chaplains do not seem to expend much energy on patients who do not express interest in spiritual issues. Their plates are already full to capacity with patients who are open to spiritual care.

7. The questionnaires for patients were reviewed. The site team felt it was a good idea to include the Spiritual Well Being Inventory. This packet is purchased, and includes a description of measurement criteria and interpretation of results. The packet also includes a list of all the research projects that have used this inventory. For our purposes, the profile will be used on the first week, and again on the fourth week.

8. The Site team felt strongly that patients who agree to participate in this study ought to be encouraged to stay with it for the four weeks.

9. The Data base was discussed and Mary T. spoke of the resources that had already been complied. These will be available in print form as well as on the web page.

Next meeting is scheduled for **November 13, 5:00pm** - 1151 N. Country Rd., Stony Brook. 631 689 5353 – marytoneill@optonline.net

MINUTES FROM SITE TEAM MEETING

NOVEMBER 13, 2006

Agenda:

- 1. Web resource list
- 2. Update on the progress of the 4-week follow up calls

1. The Web resource list is prepared, with a brief description of each site. It is mostly Christian and Roman Catholic, though there are sites that are inclusive of all faiths and give links to every known affiliation. A copy is attached to these minutes.

Next step is to work on resources for persons who do not have computer access. These will include

- retreat houses,
- books,
- phone numbers for information about religious groups/denominations,
- perhaps some poem prayers and generic spiritual practices guides, etc.

2. Progress with 4-week follow up calls:

To date, there are 13 discharged patients in the process of follow up. Some of the issues related to services and needs that are other than spiritual – and these get referred back to Social services, or Catholic charities.

It was suggested that the forms identify the Interviewers as

- male/female
- clergy/lay
- foreign born/ US citizen

to help evaluate the findings and to clarify cooperation vs consistent difficulty.-
since all information will be tainted by circumstances, and patients may give the chaplain the answers he/she thinks the chaplain wants to hear.

There was some discussion about doing a 1st round of follow up and then evaluate the findings to see if the data is significant, or perhaps the questions might need to be tweaked. Mary T described this as part of a larger project that will continue and develop into the Pastoral Healing Community plan – this aspect is the preliminary and will be continued and perhaps turned into a 2-year longitudinal study that will yield some significant findings.
Those present encouraged Mary T to keep her eye on the original deadline, let this be the preliminary study it was intended to be, and to not entertain an extension at this time.

A Blessed and happy Thanksgiving to all.
Next meeting is scheduled **for December 11, 5:00pm** – location to be decided.

The December meeting was cancelled.

APPENDIX D

AUTHORIZATION TO USE SWBS

Life Advance, INC.
81 Front Street
Nyack, NY 10960
(845) 353-2020 ext. 6945
lifeadvance@hotmail.com
www.lifeadvance.com

October 25, 2006

Mary T. O'Neill
51 Terryville Road
Port Jefferson Station, NY 11776

Dear Ms. O'Neill,

Thank you for your order of the Spiritual Well-Being Scale Specimen Set, Bibliography, and Spiritual Well-Being Scales. Enclosed you will find the Specimen Set, which also includes one copy of the Scale in addition to your purchase of 50 Spiritual Well-Being Scales. If you would like to use additional copies of the Scale in your research, please use the enclosed form to order them through Life Advance, Inc.

You are granted permission to use the Spiritual Well-Being Scale in your research. Please be aware that the Spiritual Well-Being Scale is copyrighted and may not be reproduced without expressed written consent from Life Advance, Inc., 81 Front Street, Nyack, New York 10960.

We wish you well in your research. If you would like more information on the SWBS or Life Advance, Inc. please visit our website at www.lifeadvance.com. We are delighted to be of assistance to you and look forward to a continuing working relationship.

Sincerely,

Craig W. Ellison

Craig W. Ellison, Ph.D.
President

Enclosures

mf

APPENDIX E

Individual Spiritual Well Being score and differences in the 18 patients between Weeks 1 & 4

ID	SPWB W1	SPWB WK4	DIFF_TOTAL
1	82	83	1
2	69	61	-8
3	80	84	4
4	83	87	4
5	75	104	29
6	90	109	19
7	73	67	-6
8	67	66	-1
9	84	83	-1
10	90	80	-10
11	70	68	-2
12	62	69	7
13	90	86	-4
14	91	76	-15
15	101	106	5
16	100	84	-16
17	106	88	-18
18	81	77	-4

Individual Religious Well Being Score and differences in the 18 patients between Weeks 1 & 4

ID	RELIG_SPWB_W1	RELIG_SPWB W4	DIFF
1	46	47	1
2	36	34	-2
3	40	48	8
4	45	50	5
5	37	51	14
6	43	60	17
7	33	26	-7
8	34	35	1
9	48	47	-1
10	48	40	-8
11	34	35	1
12	29	32	3
13	45	44	-1
14	40	42	2
15	49	50	1
16	50	48	-2
17	57	44	-13
18	44	43	-1

Individual Existential Well Being Scores and differences in the 18 patients between weeks 1 & 4

ID	_EXSTWB_W1	EXST_SPWB_W4	DIFF.
1	36	36	0
2	33	27	-6
3	40	36	-4
4	38	37	-1
5	38	53	15
6	47	49	2
7	40	41	1
8	33	31	-2
9	36	36	0
10	42	40	-2
11	36	33	-3
12	33	37	4
13	45	42	-3
14	51	34	-17
15	52	56	4
16	50	36	-14
17	49	44	-5
18	37	34	-3

APPENDIX F

RESOURCE BOOKLET

SPIRITUAL RESOURCES FOR DIFFICULT TIMES

APPENDIX G

POWER POINT PRESENTATION OF PROJECT

The Matthew Project:
Bridging the Self and the Sacred

A Study from Hospital to Home
of Pastoral Encounters
with Spiritually Disengaged Patients

Introduction

Origin of The Matthew Project

Challenge Statement

A Study from Hospital to Home

When hospitalized, people who are not connected to a faith community can struggle to find meaning and comfort in their lives. A pastoral encounter may facilitate their reconnection with their inner spirit.

Chaplains/CPE students will continue telephone contact with such patients when discharged from the hospital in order to serve as a bridge that facilitates the discovery of or reconnection to a spiritual support network within the community.

Focus: Patient Population

- **1. Meet patient at bedside: get assent to participate**
- **2. Weekly follow up conversations to provide continued spiritual care**
- **3. Prepare resource for spiritual nurture with multiple references**

Religious Demographics

Significant shifts in USA

- ✓Population classified as Christian has declined from 86% in 1990 to 77% in 2001
- ✓Non-Christian groups gone from 5.8 mil. to 7.7 million
- ✓No rel. identification: from 14.3 million to 29.4 million (8% to 14%)

Pivotal Question

What sustains persons
in difficult times of illness?

Goals:

1. Identify patients
2. Provide spiritual support
3. Link persons with sources of spiritual support

The Matthew Project:

"Come to Me all who labor and are heavily burdened..."

- **Relevance of the passage to the project**
- **The invitation**

Theological Implications

Suffering of the human spirit

Lonergan:
Disregard for one's
self-transcendence = alienation

Theological Implications

Lonergan's transcendental precepts:

- be attentive,
- be intelligent,
- be reasonable,
- be responsible. If necessary,
- change.

Method of CPE - Boisen

- **Action – Reflection**
- **Living Human documents**
- **Engage – Explore – Discover – Awaken**

Elements for Investigation: Lonergan

Experience
Inquiry
Understanding
Formulating
Reflecting
Checking
Judgment
Deciding the conclusion

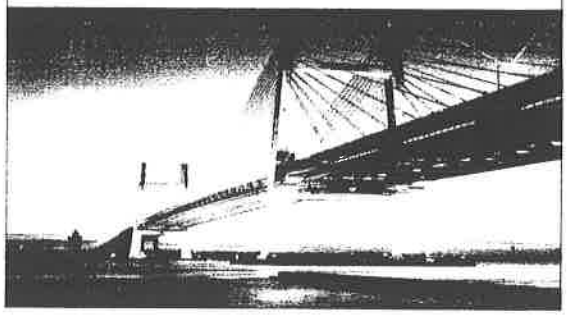
Theology

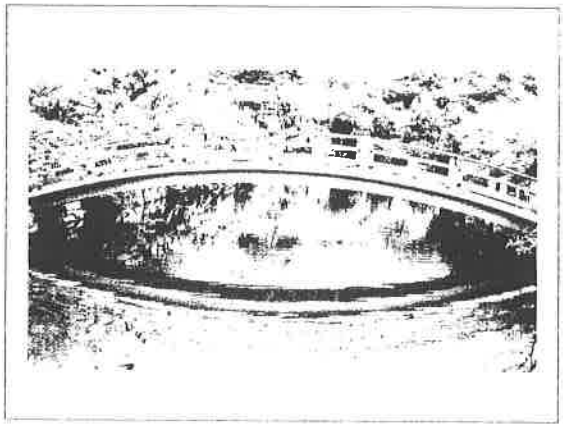
- **Unpacking the Revelation of God in human experience**
- **Bridging human experience with transcendent**

Theologies of Long Island

- Bridges and Tunnels
- Harbors and Marinas
- Tides
- Vineyards .
- Farms

Theology of Bridges and Tunnels



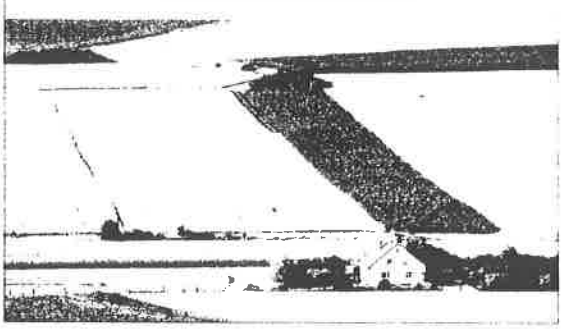


Theology of Harbors and Marinas

Theology of Tides

Theology of Vineyards

Theology of Farms



Implementation of Project

- **Goals**
- **Interviewers (2 chaplains & 4 CPE students)**
- **Target population**
- **Pre-survey**
- **Week 1 - SWBS**
- **Weeks 2 and 3**
- **Week 4: SWBS**
- **Follow-up booklet**

Findings

- 18 Patients participated
  44% never connected with any faith community; 56% were but not in many years.
- No significant quantitative change in SWBS
  (difference not statistically significant: -.89)
  Noted moderate level of spiritual well-being
- Significant qualitative responses

Qualitative Responses:

- Three pts requested that calls continue because they were so comforted that someone cared.
- "I have no one to listen to me & my worries. You did that and I am grateful"
- "You helped me find a channel to relate to God. I was afraid. I still am, but now I trust God is with me."
- "I lost God through my addictions. Now I feel I can reclaim a part of myself and that feels good."

Qualitative Responses:

- "I feel I am coping better. Your calls really help me."
- "Thanks for listening. And for calling when you said you would."
- "I feel physically sick, but not spiritually. Talking helped".

Spiritual Resources Booklet

Spiritual Resources for Difficult Times

Introduction
1. Help in Time of Need
2. Web Sites for Prayer, Reading, Religious information
3. Sacred Quotes from World Religions
4. Helpful Books
5. Retreat Resources
6. Selected Quotes, Prayers, Poems
7. Helpful information
8. Feedback page

Evaluation Process

- Small number of patients/interviewers
- Time limitations
- 17% of patients chose to link with spiritual resource within the community
- 83% were either
  a) not interested at this time, or
  b) they would do so when they were ready.

Evaluation, cont.

- All were welcoming of resource information
- Resource booklet modifications

Did Patients Bridge with The Sacred in their Lives?

- SWBS showed patients already had a moderately good connection with their spirituality, and did not show much change.
- Quantitatively, the four week telephone pastoral conversations were meaningful, supportive, and helpful.

Did Patients Bridge with The Sacred in their Lives?

- The call of God, "Come to me and I will give you rest" was heard in the patient's willingness to participate
- These calls and the interventions of chaplains were reminders of the presence and care of God – whether this was articulated in this way or not.

Transformation

For Patients

- SWBS – no affiliation but moderate level of spiritual well-being.
- Important role of chaplain in care of the sick

Transformation

For Students

- **Worked conscientiously to connect by phone.**
- **Language difficulties**

Transformation

For Me

- **Spiritual elitism**
- **Non religious world-view: our net too small**
- **Need for research by chaplains**

Transformation

Spiritual Resources for Difficult Times:

- Preparing it was transformational
- The cry of the heart in all cultures is one
- Because of this project, we can offer patients their own portable "bridge"

Next Steps

Build Bridges

- **"Under construction"**
- **Build bridges to the spirit**

Build Sanctuary

- **Harbors and marinas: chaplain as reassuring beacon in the choppy sea of change**
- **Tides: chaplain can be the shore at low tide, receiving whatever washes up; or at high tide, can be the anchor that helps reduce struggle and gives rest.**

Build Community:

- **Come to me all who labor...**
- **Pastoral Healing Communities**

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